

091007

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE REGISTRAR Adolph E. Lindhorst

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Adolph E. Lindhorst			2a DATE OF DEATH MONTH DAY YEAR March 22, 1985		2b HOUR 4A. M.	
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR Feb. 25, 1914		
6 AGE (IN YEARS LAST BIRTHDAY) 71		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3225 Rosalie Ave.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Balto. Type		
12b KIND OF BUSINESS OR INDUSTRY		13a STATE Maryland				
13b COUNTY		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e STREET ADDRESS / ZIP CODE 3225 Rosalie Ave. 21234		14 FATHER'S NAME FIRST MIDDLE LAST Henry Lindhorst				
15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena Tringel		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				
16b SOCIAL SECURITY NO. 549341215		17 INFORMANT FAMILY RECORDS				
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>POST-STATIC CARDIOPULMONARY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Approximate interval between onset and death: <u>3 weeks</u> <u>7 months</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a DATE OF OPERATION 2/13/85		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Transfused cell and platelets		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (the hospital) attended the deceased from <u>August 19 84</u> to <u>22 March 19 85</u> that (I) <input checked="" type="checkbox"/> saw the deceased alive on <u>March 12 19 85</u> and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (If two physicians did not view the body after death)						
22b SIGNATURE <u>Harry S. Stevens M.D.</u>		DEGREE M.D.		22c DATE SIGNED 3/22/85		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Harry S. Stevens M.D.		22e ADDRESS 600 West Northern Parkway BALTO 21214				
23a BURIAL, CREMATION, REMOVAL (CHECK) BURIAL		23b DATE 3-25-1985		23c NAME OF CEMETERY OR CREMATORY PARKWOOD CEM.		
23d LOCATION CITY OR TOWN COUNTY STATE PARKVILLE BALTO. MARYLAND		24 FUNERAL DIRECTOR NAME ADDRESS EVANS CHAPEL OF MEMORIES 8800 HARFORD Rd.				
25a DATE REC'D. BY REGISTRAR MAR 26 1985		25b REGISTRAR'S SIGNATURE <u>Adolph E. Lindhorst</u>				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8508181

1- STATE  
REGISTRAR

REG. NO.

09-2017

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUTH G. VACEK

2a. DATE OF DEATH MONTH DAY YEAR 3 9 85

2b. HOUR 10:40 AM

3 SEX Female

4. RACE Caucasian

5. DATE OF BIRTH MONTH DAY YEAR 04 06 18

6 AGE (IN YEARS (LAST BIRTHDAY)) 66 YRS

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland

7b. CITIZEN OF WHAT COUNTRY? USA

8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.

10 CITY OR TOWN OF DEATH Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ of Maryland Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EXEC. SECRETARY

12b. KIND OF BUSINESS OR INDUSTRY C.P.A.

13a. STATE Maryland

13b. COUNTY Baltimore

13c. CITY OR TOWN CATONSVILLE

13d. INSIDE CITY LIMITS? NO ☒

13e. STREET ADDRESS / ZIP CODE 1-A Holmes Ave 21228

14 FATHER'S NAME FIRST MIDDLE LAST Robert Miller

15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Hempel

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO

16b. SOCIAL SECURITY NO. 217-01-2933

17 INFORMANT ADDRESS FRANK C. VACEK, SR. 1-A HOLMES AVENUE 21228

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Respiratory Arrest

DO TO, OR AS A CONSEQUENCE OF (b) Failure to Thrive

DO TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 immediate

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

End stage Renal Disease - Hemodialysis

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 3/1, 19 85, to 3/9, 19 85, that (I) (we) lost saw the deceased alive on 3/9, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Duane Smoot M.D. DEGREE

22c. DATE SIGNED 3/9/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Duane Smoot M.D.

22e. ADDRESS 22 S. Greene St. Balt., MD 21215

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL

23b. DATE 03-13-85

23c. NAME OF CEMETERY OR CREMATORY LAKE VIEW MEM. PARK

23d. LOCATION CITY OR TOWN COUNTY STATE SKYESVILLE CARROLL MARYLAND

24. FUNERAL DIRECTOR NAME ADDRESS HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAR 12 1985

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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MAY 1 1967



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 1 8 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Catherine Valench		2a. DATE OF DEATH MONTH DAY YEAR 3 27 85		2b. HOUR 2:10 PM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 1 8 1903		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MAINE	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		10. CITY OR TOWN OF DEATH Baltimore		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore
14. FATHER'S NAME FIRST MIDDLE LAST OWEN MAULTON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SUNDERLAND		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RONALD KLINE 2753 DUNGLIN CT.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) COPD				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 3/20, 19 85, to 3/27, 19 85, that (I) (we) last saw the deceased alive on 3/27, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.		
22b. SIGNATURE Clifford L. Amend		DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/27/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Clifford L. Amend		22e. ADDRESS Sinai Hospital		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 4/1/1985		23c. NAME OF CEMETERY OR CREMATORY WESTVIEW
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CO MD		24. FUNERAL DIRECTOR NAME ADDRESS RAYMOND L. KACZOROWSKI 2525 FLEET ST		
25a. DATE REC'D. BY REGISTRAR APR 1 - 1985		25b. REGISTRAR'S SIGNATURE R. B. Anderson-Randall		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Alice</b> <b>Veanie</b>			2a. DATE OF DEATH MONTH <b>March</b> DAY <b>5</b> YEAR <b>1985</b>		2b. HOUR <b>7:14</b> pm								
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>May</b> DAY <b>10</b> YEAR <b>1942</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 72 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.							
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <b>MD</b>						13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>748 N. Denison St. 21229</b>	
14. FATHER'S NAME FIRST <b>Otis</b> MIDDLE <b>Crumbly</b> LAST <b>Hudson</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Josephine</b> MIDDLE <b>Hudson</b> LAST <b>Hudson</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>223-05-1599</b>		17. INFORMANT ADDRESS <b>Joseph N. Veanie 748 N. Denison St.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Possible Pulmonary Embolism.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <b>2/18/1985</b> to <b>3/5/1985</b> , that (I) (we) last saw the deceased alive on <b>3/5/1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Jimmy Sue M.D.</b>		DEGREE <b>M-D</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <b>3/5/85</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jimmy Sue M.D.</b>				22e. ADDRESS <b>St. Agnes Hosp. Md 21229</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/9/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Mem. Pk.</b>		23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Co.</b> STATE <b>MD</b>							
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b>				ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 7 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Richard R. Riddell</b>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRAR

REG. NO.

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY) **Burial**

23b. DATE  
3/7/85

23c NAME OF CEMETERY OR CREMATORY	Meadowridge Mem. Pk.
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73d LOCATION  
CITY OR TOWN COUNTY STATE  
Elkridge Howard Maryland

24 FUNERAL DIRECTOR

NAME	ADDRESS	PHONE
Hubbard Funeral Home, Inc.	4107 Wilkens Ave	

21229	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
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25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE  
MAR 10 1985 [Signature]

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death is pronounced by a physician or other qualified person. The death certificate should be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the coroner, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

## MEDICAL CERTIFICATION

or Item 8 shows on

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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092051

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M
 BP  
DHMH - 17  
(VR A15 ME (5))

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

08185

1- FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		M	
Anna Mary Jeanette		3 26 1985		7:20 a.m.	
2. SEX	3. RACE	4. DATE OF BIRTH	5. AGE (IN YEARS)	6. IF UNDER 1 YR.	7. IF UNDER 24 HRS.
Female	White	2 29 12	73 YRS.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9. CITIZEN OF WHAT COUNTRY?	10. MARRIED	11. NEVER MARRIED	12. DIVORCED	13. BALTIMORE CITY OR COUNTY OF DEATH
New York	U.S.A.				Baltimore City, MD
14. CITY OR TOWN OF DEATH	15. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	16a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	16b. KIND OF BUSINESS OR INDUSTRY		
Baltimore	Deaton Medical Center	Retired	----		
17a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	17b. CITY OR TOWN	17c. INSIDE CITY LIMITS?	17d. STREET ADDRESS		
17a. STATE	17b. COUNTY	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	17d. STREET ADDRESS		
Maryland			1608 E. Fort Avenue 21230		
18. FATHER'S NAME	19. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST	FIRST MIDDLE LAST				
Joseph Miller	Margaret Duiller				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS		
NO	098-16-0193	Margaret Vines	1608 E. Fort Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>End stage renal disease</u>					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					
(b) <u>Chronic obstructive pulmonary disease</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, PARK, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
		Acting Chief		3/28/85	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		BALTO. MD.	
Thomas D. Smith, M.D.		111 Penn St.		Balto. MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial	3/29/85	Holy Cross Cemetery	Brooklyn, Kings County, N.Y.		
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR	
Charles L. Stevens Funeral Home		1501 E. Fort Ave. Balto, Md.		MAR 28 1985	
				25b. REGISTRAR'S SIGNATURE	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Howard Franklin Virts		2a. DATE OF DEATH MONTH DAY YEAR March 27, 1985		2b. HOUR 8:00 PM	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR December 30, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) US Maryland	7b. CITIZEN OF WHAT COUNTRY? US USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Steel worker		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD.		13b. COUNTY Balt.	13c. CITY OR TOWN Balt.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William E. Virts		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susannah Vickers			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-10-1686		17. INFORMANT ADDRESS Chester F. Virts Baltimore, Maryland 21203	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PSEUDOMONAS PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE 3 days					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: NEGATIVE LAPAROTOMY, SEVERE DEBILITATION, ORGANIC BRAIN SYN.					
19a. DATE OF OPERATION 3/19/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PNEUMOPERITONEUM		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3/19/85 to 3/27/85, that (I) (we) last saw the deceased alive on 3/27/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Harold D. Roberts		DEGREE MD		22c. DATE SIGNED 3/27/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harold D. Roberts		22e. ADDRESS MERCY HOSP.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/30/85		23c. NAME OF CEMETERY OR CREMATORY Leesburg Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Leesburg, Loudon, Virginia					
24. FUNERAL DIRECTOR R. E. Dailey & Son, P. A.		1201 N. Market St. Frederick, Md. 21701		25a. DATE REC'D BY REGISTRAR APR 1 1985	
25b. REGISTRAR'S SIGNATURE					

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <del>VOGEL</del> RICHARD VOGEL		2a. DATE OF DEATH MONTH DAY YEAR 3 3 85		2b. HOUR 9 <sup>10</sup> A.M.
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 2 7 28		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL OF BALTIMORE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER	12b. KIND OF BUSINESS OR INDUSTRY AT&T
13a. STATE MARYLAND		13b. COUNTY BALTIMORE	13c. CITY OR TOWN RANDALLSTOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST IRVING VOGEL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GERTRUDE BLUME		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) XXXXXXX		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) KOREAN-ARMY 067-22-6580		17. INFORMANT MRS. SELMA VOGEL APT. 202 3908 NOYES CIR. RANDALLSTOWN, MD 21133

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST

DUE TO, OR AS A CONSEQUENCE OF

(b) PANCREATIC CARCINOMA

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3/2, 1985, to 3/3, 1985, that (I) (we) last saw the deceased alive on 3/3, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If well did) (did not) view the body after death.			
22b. SIGNATURE Barbara Michael		DEGREE 9264	22c. DATE SIGNED 3/3/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barbara Michael		22e. ADDRESS Sinai Hospital of Baltimore	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE MAR. 5, 1985	23c. NAME OF CEMETERY OR CREMATORY OHEB SHALOM	23d. LOCATION REISTERSTOWN BALTO. MD
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215		25a. DATE REC'D. BY REGISTRAR MAR 7 1985	25b. REGISTRAR'S SIGNATURE R. Davidson-Randall

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST TANYA WACHS			2a. DATE OF DEATH MONTH DAY YEAR March 27 1985			2b. HOUR 4:13 A.M.	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 4 19 02		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALT. CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAL HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. STATE MD		13b. COUNTY —		13c. CITY OR TOWN Balt. City		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST AARON BERYL SUSSMAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRIMMA BERNSTEIN		13e. STREET ADDRESS 2500 W. BELVEDERE AVE.		APT. 221 #21215	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 138-07-6484		17. INFORMANT BERTRAM GOLDSTEIN		3407 OVERBROOK RD. BALTO., MD 21208	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST  
DUE TO, OR AS A CONSEQUENCE OF  
(b) MYOCARDIAL INFARCTION  
DUE TO, OR AS A CONSEQUENCE OF  
(c) HYPERTENSION & DIABETES

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  
15 min  
30 hrs  
YEARS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/23</u> , 19 <u>85</u> , to <u>3/27</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>3/27</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R. C. Patel MB, BS				DEGREE MB, BS		22c. DATE SIGNED 3/27/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAJESH C PATEL				22e. ADDRESS SINAL HOSP. BELVEDERE AVE. BALTO. MD 21215			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAR. 28, 1985		23c. NAME OF CEMETERY OR CREMATORY BETH EL MEM. PARK		23d. LOCATION RANDALLSTOWN CO. BALTO. MD	
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24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 BELISTERSTOWN RD. BALTO., MD 21215		25a. DATE REC'D. BY REGISTRAR APR 2 - 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after burial with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

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FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>HILLARY I WADE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>03 16 85</b>		2b. HOUR <b>11:30AM</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 10 13</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Operator</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>Tavern Owner</b>		13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Arbutus</b>				
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>3308 Washington Blvd. 21227</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Hillary J. Wade</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Eichelman</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-09-9870</b>		17. INFORMANT ADDRESS <b>Debra L. Landsman 11706 Woodland Dr. 21093</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio pulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>renal failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 mins.</b> <b>45 mins.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>Feb 19 85</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 19 85</b> to <b>March 19 85</b> that (I) (we) lost saw the deceased alive on <b>3/16/85</b> 19 <b>85</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Alex Pomer</b>		DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/16/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Alex Pomer</b>		22e. ADDRESS <b>601 N. Wolfe St. Balto. Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/19/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>		24. FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.</b>				
25a. DATE REC'D. BY REGISTRAR <b>MAR 18 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John L. Landsman</b>				

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 24 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lawrence Wade			2a. DATE OF DEATH MONTH DAY YEAR 3/15/85			2b. HOUR 9/54M			
3 SEX Male		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 8 24 20		6. AGE (IN YEARS (LAST BIRTHDAY)) 64 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PROVIDENT HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.			13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST James R. Wade			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie E. Bell			13e. STREET ADDRESS / ZIP CODE 3040 W. North Ave. 21216			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW11		17. INFORMANT ADDRESS Doris Kelly 4005 Hayward Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure - Cardio- Cerebral Vascular Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF, (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF, (c) <u>Myocardial Infarction</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1/19/85 to 3/17/85, that (I) (we) last saw the deceased alive on 3/16/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert J. Williams MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/17/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT J. WILLIAMS			22e. ADDRESS 4605 EDMONDSON AVE 29						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 3/19/85		23c. NAME OF CEMETERY OR CREMATORY Westview Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.		
24. FUNERAL DIRECTOR NAME C. Wainwright					ADDRESS 2700 Edmondson Ave		25a. DATE REC'D. BY REGISTRAR MAR 19 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 08191

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>William WADSWORTH</b>			2a. DATE OF DEATH MONTH <b>03</b> DAY <b>14</b> YEAR <b>85</b> HOUR <b>7</b> PM		
3. SEX <b>MALE</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH <b>01</b> DAY <b>11</b> YEAR <b>85</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>99</b> YRS		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7c. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN A NURSING HOME, GIVE STREET ADDRESS) <b>Provident Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Baltimore City</b> MD.	
13a. STATE <b>MD.</b>		13b. COUNTY <b>Smith</b>	13c. CITY OR TOWN <b>Smith</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Wm.</b> MIDDLE <b>Wm.</b> LAST <b>Wm.</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Wm.</b> MIDDLE <b>Wm.</b> LAST <b>Wm.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>218-18-4915</b>		17. INFORMANT <b>Grandson &amp; son Ave Nursing Home</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 MIN</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASPIRATION GASTRIC FLUID</b> <b>10 MIN</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Congestive Heart Disease</b> <b>60 days</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <b>UREMIA</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <b>Richard Tyson, MD</b> attended the deceased from <b>10-06</b> 19 <b>85</b> to <b>03-28</b> 19 <b>85</b> that (I) <b>last</b> saw the deceased alive on <b>03-28</b> 19 <b>85</b> , and that in (my) <b>opinion</b> death occurred on the date and hour and from the causes stated above, (I) <b>did</b> (did not) view the body after death.					
22b. SIGNATURE <b>Richard Tyson, MD</b>		22c. DATE SIGNED <b>03-28-85</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RICHARD TYSON, MD</b>	
22e. ADDRESS <b>936 W. NORTH 4 AV, BALTO MD 21217</b>		22f. ADDRESS <b>936 W. NORTH 4 AV, BALTO MD 21217</b>			
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>7/15/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Ambrose Co.</b>	
23d. LOCATION CITY OR TOWN <b>Smith</b>		23e. COUNTY <b>MD</b> STATE			
24. FUNERAL DIRECTOR NAME <b>Steven T. Carroll</b>		24b. ADDRESS <b>1712 W. North Ave</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 3 1985</b>	
25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>		25c. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 4/83  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 1 9 2

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) THOMAS T WAGSTAFF			2a. DATE OF DEATH MONTH DAY YEAR 3 12 85			2b. HOUR 4:35p M		
3. SEX male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Jan 13 28			6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Loch Raven Veteran Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) spotter		12b. KIND OF BUSINESS OR INDUSTRY cleaning	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Clifton Wagstaff		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Matilda Goods			13e. STREET ADDRESS / ZIP CODE 44 S. Stockton St. 21223			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1945		17. INFORMANT Bernadine Bell 3612 Hayward Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>hepatocellular carcinoma (hepatoma)</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (X) (this hospital) attended the deceased from FEBRUARY 1 1985, to MARCH 12 1985, that (X) (we) lost saw the deceased die on MARCH 12 1985, and that in (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) did not view the body after death.								
22b. SIGNATURE [Signature] MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/13/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KMETZO						22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/16/85		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel	
24. FUNERAL DIRECTOR NAME Bailey Douglass 1348 Calhoun St						25a. DATE REC'D. BY REGISTRAR MAR 14 1985		25b. REGISTRAR'S SIGNATURE [Signature]

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

DECEASED NAME (TYPE OR PRINT) <b>BERNARD WAITSMAN</b>			2a. DATE OF DEATH MONTH <b>3</b> DAY <b>5</b> YEAR <b>85</b>		2b. HOUR <b>1142A</b>
3. SEX <b>Male</b>	4. RACE <b>Cauc</b>	5. DATE OF BIRTH MONTH <b>9</b> DAY <b>26</b> YEAR <b>18</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALT CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PRINTER</b>		12b. INDUSTRY OR BUSINESS OR INDUSTRY <b>TICKET CO.</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>BALTIMORE</b> 13c. CITY OR TOWN <b>BALTIMORE</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>6606 PARK HTS AVE. 21215</b>
14. FATHER'S NAME FIRST <b>SIMON</b> MIDDLE <b>WAITSMAN</b> LAST <b>WAITSMAN</b>		15. MOTHER'S MAIDEN NAME FIRST <b>TILLIE</b> MIDDLE <b>SCHEIDT</b> LAST <b>SCHEIDT</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b> (IF YES, GIVE WAR OR DATES) <b>WWII-ARMY</b>		16b. SOCIAL SECURITY NO. <b>213-09-8770</b>		17. INFORMANT <b>MRS. MIRIAM WAITSMAN</b> APT. 305 <b>6606 PARK HTS. AVE. #21215</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MET Lung CA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>3-5</b> <b>1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Steven J. Garon</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3-5-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>STEVEN GARON</b>		22e. ADDRESS <b>SINAI HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>MAR. 6, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MIKRO KODESH-BETH ISRAEL</b>	
23d. LOCATION CITY OR TOWN <b>BALTIMORE</b> COUNTY <b>MARYLAND</b>					
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 14 1985</b>		25b. REGISTRAR'S SIGNATURE <b>P. K. [Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 1 9 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Nicole P Wallace</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>March 6 1985</b>		2b. HOUR <b>10<sup>30</sup> AM</b>
3. SEX <b>Female</b>	4. RACE <b>black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>2/22/85</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>0</b> YRS <b>0</b> MONTHS <b>12</b> DAYS <b>+</b> HOURS <b>+</b> MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University of Maryland Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>-</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>569 Baker St., 21217</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Theodore Bees</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jacqueline R Wallace</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Central Hypoventilation</b> (c) <b>Intraventricular Hemorrhage</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Hypernatremic Dehydration</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>March 3 1985</b> to <b>March 6 1985</b> that (I) (we) last saw the deceased alive on <b>March 6 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Judith R. DeJarnette</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>5/3/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Judith R. DeJarnette</b>		22e. ADDRESS <b>Dpt of Pediatrics, University Hospital 22 S. Greene St, Baltimore, Maryland 21201</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>3/8/85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Cem.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Jeff Miller F.S. 4609 Park Hqs</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 12 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Lin Tilden Radtke</b>	

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page. The text appears to be organized into several paragraphs.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8195

1- FOR  
STATE  
REGISTRAR

DECEASED NAME (TYPE OR PRINT) <b>WARREN A LLEN WALLS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 - 1 - 85</b>			2b. HOUR <b>6:30 A.M.</b>				
1. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 - 16 - 14</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Georgia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Good Samaritan Hospital</b>				12a. USUAL OCCUPATION (TYPE AND MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Balto. Gas &amp; Electric</b>		
13a. STATE <b>MD</b>			13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>409 Seagull Ave.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Warren A. Walls, Sr.</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillian Unknown</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>WW II 213-05-3295A</b>		17. INFORMANT <b>3514 Rockdale Court</b> <b>Carolyn Gadson Baltimore, Maryland 21207</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>(R) Cerebral Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b> <b>6 weeks</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION <b>Feb. 11 1985</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) this hospital attended the deceased from <b>Feb. 11 1985</b> , to <b>March 1 1985</b> , that (I) <del>was</del> <b>last</b> saw the deceased alive on <b>Feb. 28 1985</b> , and that in my <del>own</del> <b>professional</b> opinion death occurred on the date and hour and from the causes stated above, (I) <del>we</del> <b>(I)</b> <del>did</del> <b>view</b> the body after death.										
22b. SIGNATURE <b>Jeffrey B. Palmer MD</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/1/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jeffrey B. Palmer, MD</b>			22e. ADDRESS <b>5601 Loch Raven Blvd, Balto, MD 21239</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3/6/1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem. Baltimore,</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24. NUMBER OF SONS <b>2501</b>			24b. ADDRESS <b>Gwynns Falls Parkway</b>			24c. DATE REC'D. BY REGISTRAR <b>MAR 6 1985</b>		24d. REGISTRAR'S SIGNATURE <b>John Davidson</b>		
24e. FUNERAL HOME, INC. BALTIMORE, MARYLAND 21216										

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

8192

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

65-123

DATE

TO

FROM

SUBJECT

U. S. DEPARTMENT OF JUSTICE

MEMORANDUM

TO :

FROM :

SUBJECT :

RE: [Illegible]

[Illegible]

[Illegible]

[Extremely faint, illegible body text]

U. S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535



BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR <b>AIDAN EDWARD WALSH</b>		REG. NO.		8508196					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Aidan Edward Walsh Sr.</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>March 1, 1985</b>				2b. HOUR <b>10 A.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct 25 1932</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>52</b> YRS.		7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ireland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD.</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MIEMSS</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Physician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HEALTH CARE</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry Walsh</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sheila O'Reilly</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216-42-8805</b>		17. INFORMANT ADDRESS <b>FRANCES T. WALSH 2103 CEDAR CIRCLE DRIVE</b>				21228	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebral infarct</b> <b>8261</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>comminuted depressed skull fracture</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b> <b>24 hrs</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>none</b>									
19a. DATE OF OPERATION <b>Feb 28 1985</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>depressed skull fractures</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>3 P.M. Feb 28 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART 1 OR PART 2) <b>fall from bicycle</b> <b>ACCIDENT</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>street</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Dogwood Rd. nr. Wright Mill Baltimore Md</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 28</b> , 19 <b>85</b> , to <b>March 1</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>March 1</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Jonathan Greenberg MD</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>March 1, 1985</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jonathan Greenberg MD</b>				22e. ADDRESS <b>MIEMSS 22 South Greene St. Baltimore</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>MARCH 5, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CREST LAWN CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>MARIOTTSTVILLE MARYLAND</b>			
24. FUNERAL DIRECTOR <b>LEROY M. &amp; RUSSELL C. WITZKE FUNERAL HOME OF CATONSVILLE</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 4 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Davidson-Randell</b>	
1630 Edmondson Avenue Catonsville Maryland 21228									

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) RUTH A. WALTERMEYER			2a. DATE OF DEATH MONTH DAY YEAR 3 7 85			2b. HOUR 7 P.M.			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 8, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH V BALTIMORE City MD.			
10. CITY OR TOWN OF DEATH BALTIMORE CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Ritz Enterprises	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY ---		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST August Waltemeyer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa Rice					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --		17. INFORMANT ADDRESS 216-16-3428 Gene Harris, dghtr, same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory arrest</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>aspiration</u>								30 min	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>pancreatic cancer</u>								4 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>none</u>									
19a. DATE OF OPERATION 2/9/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED pancreatic cancer				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1/23 19 85, to 3/7 19 85, that (I) (we) lost saw the deceased alive on 3/7 19 85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R. Chisholm				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 3/7/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. Chisholm				22e. ADDRESS UNION MEMORIAL HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/11/85		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto, Md.			
24. FUNERAL DIRECTOR NAME SCHIMUNEK FUNERAL HOME, Balto, Md. 21213				25a. DATE REC'D. BY REGISTRAR MAR 13 1985		25b. REGISTRAR'S SIGNATURE Davidson-Randall			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and that it be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death, and that it be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

REPORT

UNITED STATES ARMY

WASHINGTON, D. C.

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UNITED STATES ARMY

WASHINGTON, D. C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

Film G603 Item 13c &amp; 13d

FOR 5/14/85 rja

STATE REGISTRAR William R. Walter

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 1 9 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>William Robert Walter</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>March 03, 1985</b>		2b. HOUR <b>2:15 PM</b>	
3. SEX <b>Male</b>		4. RACE <b>caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>05 19 35</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>49</b>	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Foreman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>F.M.C. Corp</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>				13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE <b>4006 Orchard Ave. 21225</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George P. Walter</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Dorothy T. Braumbart</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213 32 3244</b>		17. INFORMANT ADDRESS <b>Roberta Walter same as 13 e</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GASTROINTESTINAL HEMORRHAGE, MASSIVE</b> DUE TO, OR AS A CONSEQUENCE OF b) <b>ADENOCARCINOMA OF THE LUNG WITH</b> DUE TO, OR AS A CONSEQUENCE OF c) <b>WIDE SPREAD METASTASES</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>16</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Michael E. Blegan</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/4/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/7/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brooklyn A.A. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>George J. Gonce</b>				24b. ADDRESS <b>Balto. Md. 21225</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 5 1985</b>	
25b. REGISTRAR'S SIGNATURE <b>Davidson-Randall</b>							

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SECRET

288 J. L. Koss

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 1 9 9

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>ELIZABETH</u> MIDDLE <u>MARY</u> LAST <u>WALTERS</u> <i>Elizabeth walter</i>		2a. DATE OF DEATH MONTH <u>03</u> DAY <u>24</u> YEAR <u>85</u>		2b. HOUR <u>11:45am</u>	
3. SEX <u>Female</u>		4. RACE <u>white</u>		5. DATE OF BIRTH MONTH <u>02</u> DAY <u>20</u> YEAR <u>14</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Trenton N.J.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>71</u> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <u>Francis Scott Key Medical Center</u>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MAINT. OF WORKING LIFE) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>Dundalk</u>	
14. FATHER'S NAME FIRST <u>Joseph</u> MIDDLE <u>Hunt</u> LAST		15. MOTHER'S MAIDEN NAME FIRST <u>Mary</u> MIDDLE <u>Yates</u> LAST		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>153 18 6327</u>		17. INFORMANT ADDRESS <u>George I. Walters, Husband</u> <u>Same</u>	

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) cardiovascular arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) gross & acute

DUE TO, OR AS A CONSEQUENCE OF

(c) secondary left sided pneumonia

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

COPD

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>3/24</u> , 19 <u>85</u> , to <u>3/24</u> , 19 <u>85</u> , that (1) (we) lost <u>saw the deceased alive on</u> <u>3/24</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Brenda N. Cogan MD</u>				DEGREE <u>MD</u>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>		23b. DATE <u>3/28/85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		23d. LOCATION CITY OR TOWN <u>Baltimore Co., Md.</u> COUNTY STATE	
24. FUNERAL DIRECTOR <u>Brzezinski Funeral Home PA</u>				25a. DATE REC'D. BY REGISTRAR <u>MAR 26 1985</u>		25b. REGISTRAR'S SIGNATURE <u>Jane Davidson-Pondale</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove co-bonopapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

088117





Handwritten notes and markings, possibly a signature or initials, located in the upper center of the page.

Handwritten text, possibly a date or reference number, located in the upper left quadrant.

Handwritten text, possibly a date or reference number, located in the upper right quadrant.

Handwritten text, possibly a date or reference number, located in the middle left quadrant.

Handwritten text, possibly a date or reference number, located in the middle right quadrant.

Handwritten text, possibly a date or reference number, located in the center of the page.

Handwritten text, possibly a date or reference number, located in the lower left quadrant.

Handwritten text, possibly a date or reference number, located in the lower left quadrant.

Handwritten text, possibly a date or reference number, located in the lower right quadrant.

Handwritten text, possibly a date or reference number, located at the bottom left.

Handwritten text, possibly a date or reference number, located at the bottom right.

Handwritten text, possibly a date or reference number, located at the very bottom of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 0 8 2 0 0

082052

1. DECEASED NAME (TYPE OR PRINT) <b>Edward J. Wanek</b>			2a. DATE OF DEATH MONTH <b>March</b> DAY <b>7</b> YEAR <b>1985</b> 2b. HOUR <b>11:32</b> P		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>8</b> DAY <b>29</b> YEAR <b>1914</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FSKMC</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Dundalk</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>2468 KeyWAY 21222</b>	
14. FATHER'S NAME FIRST <b>Christian</b> MIDDLE <b></b> LAST <b>Wanek</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Katherine</b> MIDDLE <b></b> LAST <b>Splonk</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-09-3455</b>	17. INFORMANT <b>#2 Thummont Court Apt. 2-D</b> <b>Baltimore, Maryland 21236</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>ATHROSCLEROTIC CARDIOVASCULAR DISEASE</b>					<b>YEARS</b>
DUE TO, OR AS A CONSEQUENCE OF (c) <b>SEVERE CONGESTIVE HEART FAILURE (ESPECIALLY FRAGILE)</b>					<b>YEARS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>3 17 19 85</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <b>3/7</b> , 19 <b>85</b> , to <b>3/7</b> , 19 <b>85</b> , that (I) <del>was</del> lost saw the deceased alive on <b>3/7</b> , 19 <b>85</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, <del>or was</del> (did not) view the body after death.					
22b. SIGNATURE <b>William M. Simpson, Jr.</b>		DEGREE <b>MD.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/8/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William M. Simpson, Jr.</b>		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/11/1985</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE <b>Maryland</b>
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b> ADDRESS <b>7922 Wise Avenue Dundalk, MD. 21222</b>			25. DATE REC'D. BY REGISTRAR OR DESIGNATED SIGNATURE <b>MAR 11 1985</b> <b>Julia Davidson</b>		

BP

100-111329

Edward J. Warner  
Male  
Born 10/11/1913  
Bottoms City  
Mississippi

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASHINGTON, D. C. 20535  
JAN 14 1964



3/2/64

100-111329-1  
JAN 14 1964

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8508201

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>RUBY</b> <b>WARD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3/2/85</b>		2b. HOUR <b>9:45</b> AM			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 19 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Deaton Hospital and Med. Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lawrence Derry</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Julia Grove</b>		16. ADDRESS <b>611 S. Chas. St., Balto., Md. 21230</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No -</b>		16b. SOCIAL SECURITY NO. <b>216-03-</b>		17. INFORMANT <b>Joycelyn L. Flynn, 15B Nutmeg Knoll Ct.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pneumonia / CHF</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>3 days</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>May 24 1984</b> to <b>Mar 2 1985</b> , that (I) (we) last saw the deceased alive on <b>Mar 2 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Ron Wish</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/2/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ron Wish</b>		22e. ADDRESS <b>Deaton Med Center Balto.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/5/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Cm.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Timonium Balto. Md.</b>		
24. FUNERAL HOME <b>Bryan W. Clary</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 5 1985</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		
26. ADDRESS <b>Bryan W. Clary, 10 W. Padonia Rd. 21093</b>								

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

2420

0507

077022

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) William c. Ward		2a. DATE OF DEATH MONTH DAY YEAR 3 8 85		2b. HOUR 10:10AM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 3 1 04		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD		10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pleasant Manor Nur. Cen.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steam Fitter		12b. KIND OF BUSINESS OR INDUSTRY Local #438		13a. STREET ADDRESS 404 Venable Avenue 21218	
13b. STATE Md.		13c. COUNTY Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John B. Ward		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Kirwan		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 705-05-0987		17. INFORMANT John Hastman		ADDRESS 7860 Charlesmont Rd. Balto, MD. 21222	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Alzheimer's Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 year</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>None</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>April 11</u> 19 <u>75</u> to <u>March 8</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>March 8</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (didn't) view the body after death.					
22b. SIGNATURE <u>Manuel Levin</u>		DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3/8/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MANUEL LEVIN, M.D.</u>		22e. ADDRESS <u>6101 PK HTS. AVE BALTO. MD 21244</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>3/11/1985</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	
23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore Maryland</u>		24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue Dundalk, MD. 21222			
25a. DATE REC'D. BY REGISTRAR <u>MAR 14 1985</u>		25b. REGISTRAR'S SIGNATURE <u>John H. Anderson-Randall</u>			

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

THE END



077021

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

875

08203

1- STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Wallace K. Ware			2a. DATE OF DEATH MONTH DAY 1985 March 03 11 85		2b. HOUR 1:10 PM
3 SEX Male	4. RACE Black	5. DATE OF BIRTH DAY MONTH YEAR April 04 14 1915		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Mercy Hospital		12a. USUAL OCCUPATION (IF WORKER OR MANUFACTURING)		12b. KIND OF BUSINESS OR INDUSTRY Truck Driver
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland			13b. COUNTY	13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME James			15. MOTHER'S MAIDEN NAME Mary		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 212125189		17. INFORMANT ADDRESS Mary E. Ware/229 N. Monastery St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory collapse</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic tumor</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>3/7</u> , 19 <u>85</u> , to <u>3/11</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3/11</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE William Waschler		DEGREE MD		22c. DATE SIGNED 3/11/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM WASCHLER		22e. ADDRESS MERCY			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 3-16-85		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial	
23d. LOCATION Arbutus (Balto.) Md.		23e. NAME OF CEMETERY OR CREMATORY		23f. LOCATION	
24. FUNERAL DIRECTOR Marshall W. Jones, Jr./4101 Edmondson Ave		25a. DATE REC'D. BY REGISTRAR MAR 14 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



082026

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 2 0 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE ROSE LAST WASARHELYI			2a. DATE OF DEATH MONTH DAY YEAR 3-4-85		2b. HOUR 9:45 PM						
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 29 16		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
9. BIRTHPLACE (COUNTRY) Pennsylvania		10. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD					
13. CITY OR TOWN OF DEATH Baltimore		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			16. KIND OF BUSINESS OR INDUSTRY ---		
17. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a. STATE MARYLAND 17b. COUNTY BALTIMORE 17c. CITY OR TOWN BALTO. HIGHLANDS 17d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 17e. STREET ADDRESS / ZIP CODE 2765 YARNALL ROAD 21227											
18. FATHER'S NAME FIRST IGNATZ MIDDLE LAST ST. PETER				19. MOTHER'S MAIDEN NAME FIRST ROSE MIDDLE LAST BARTLOSC							
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				21. SOCIAL SECURITY NO. 217-26-4408		22. INFORMANT ADDRESS ALEXANDER WASARHELYI 2765 YARNALL RD. 21227					
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Acute inf. and lat. m.i. DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: A-f. fibrillation, pul. edema.											
24. DATE OF OPERATION				25. CONDITION FOR WHICH OPERATION WAS PERFORMED				26. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
31. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				32. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		33. LOCATION STREET CITY OR TOWN COUNTY STATE					
34. I certify that (I) (this hospital) attended the deceased from 3-3-85, to 3-4-85, that (I) (we) last saw the deceased alive on 3-4-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
35. SIGNATURE EDNA S YEO				36. DEGREE ST AGNES HOSP				37. DATE SIGNED 3-4-85			
38. PHYSICIAN'S NAME (TYPE OR PRINT)				39. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 3/8/85		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BROOKLYN PK. A.A. MARYLAND			
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE				25. ADDRESS 21229		26. DATE REC'D. BY REGISTRAR MAR 6 1985		27. REGISTRAR'S SIGNATURE K. J. J. J.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.

6-1-59

2029 COLLOIDAL LITE

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8508205

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Alice R Washington</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3 30 85</i>		2b. HOUR MIN. <i>6 45</i> M		
3. SEX <i>Female</i>		4. RACE <i>black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>8 7 19</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>65</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Baltimore Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City, MD.</i>	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>University of Maryland</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YEAR) <i>secretary</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>nursing home</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <i>1216 Oakhurst Pl.</i>		13f. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City, MD.</i>		13g. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City, MD.</i>		13h. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City, MD.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles T. Simms</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Rachael A. Watts</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>unknown</i>		16b. SOCIAL SECURITY NO. <i>220-22-1885</i>	
17. INFORMANT NAME <i>Barbara Reid</i>		17. INFORMANT ADDRESS <i>2408 Winchester St. Apt. H</i>		17. INFORMANT ADDRESS <i>2408 Winchester St. Apt. H</i>		17. INFORMANT ADDRESS <i>2408 Winchester St. Apt. H</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>breast respiratory failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>breast carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>chronic obstructive pulmonary disease</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>2 yr</i>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *chronic obstructive pulmonary disease*

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. LOCATION STREET CITY OR TOWN COUNTY STATE		21h. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>3/30</i> , 19 <i>85</i> , to <i>3/30</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>3/30</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Barbara A. Conley MD</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>3/30/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>BARBARA A. Conley MD</i>		22e. ADDRESS <i>UMCC 22 S. Greene St Baltimore</i>		22f. ADDRESS <i>UMCC 22 S. Greene St Baltimore</i>		22g. ADDRESS <i>UMCC 22 S. Greene St Baltimore</i>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>4/5/85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mount Auburn Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Wm C March F/H, Inc, 1101 E North Avenue</i>				25a. DATE REC'D. BY REGISTRAR <i>APR 1 - 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>	

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2002 COTTON 2003

WILLIAMS



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0820/27

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR			
MARY		E.		WASHINGTON				March		2		85		7 P		M			
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)				7. IF UNDER 1 YEAR				8. IF UNDER 72 HRS			
FEMALE		BLACK		MONTH DAY YEAR 6-13-1905				79 YEARS old YRS				MONTHS DAYS HOURS MIN.							
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		10. CITIZEN OF WHAT COUNTRY?		11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				12. BALTIMORE CITY OR COUNTY OF DEATH											
BALTO		United States						Baltimore, Maryland MD											
13. CITY OR TOWN OF DEATH		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										15a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				15b. KIND OF BUSINESS OR INDUSTRY			
BALTO		Bon Secour Hosp.																	
16a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		16b. STATE		16c. COUNTY		16d. CITY OR TOWN		17a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		17b. STREET ADDRESS / ZIP CODE									
Md		A. A.		BALTO						203 BRIMFIELD Rd. 2112									
18. FATHER'S NAME						19. MOTHER'S MAIDEN NAME						20. ADDRESS							
FIRST MIDDLE LAST Andrew Monroe						FIRST MIDDLE LAST Nannie BLAKE													
21a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)						21b. SOCIAL SECURITY NO.						22. INFORMANT							
						216-A3-5359													

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Shock - to the myocardium - failure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHF, pneumonia, renal failure</u>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypothyroidism &amp; anemia</u>	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) [this hospital] attended the deceased from <u>1/30</u> , 19 <u>81</u> , to <u>3/2</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>3/2</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Forens. Pathology</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>3/3/81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ROSENBERG, S. A. M. D.</i>				22e. ADDRESS <i>Box 222222, New York</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>3-11-85</i>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN <i>Baltimore</i> COUNTY <i>Harford</i>
24. FUNERAL DIRECTOR NAME <i>Brown/Thompson F.H.</i> ADDRESS <i>1913 W. Balt. St.</i>		25a. DATE REC'D. BY REGISTRAR <b>MAR 8 1985</b>	25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>





080012

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 2 0 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM A. WATERS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 6 1985</b>			2b. HOUR <b>015A<sub>M</sub></b>	
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>OCT. 5, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LABORER</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD.</b>				13b. COUNTY <b>Montg.</b>		13c. CITY OR TOWN <b>Garthersburg</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Snowden</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>578-01-7809</b>		17. INFORMANT ADDRESS <b>William W. Waters (son) 848 West Side Dr. Garthersburg, Md.</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Cardiovascular collapse**

DUE TO, OR AS A CONSEQUENCE OF

(b) **Multiple organ failure**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Chronic alcoholism**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>3.5. 1985</b> to <b>3.6. 1985</b> , that (I) (we) lost saw the deceased alive on <b>3.6. 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Raul Lopez</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3.6.85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Raul Lopez</b>		22e. ADDRESS <b>2600 Liberty Heights Baltimore</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>3-16-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Fun. Home</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR NAME <b>George R. Snowden</b>		ADDRESS <b>246 N. Wash. St. Rockville, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 15 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson</b>	

*[Faint, illegible handwritten text covering the page]*

4 087081

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 2 0 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Geneva Watkins</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 20 85</b>			2b. HOUR <b>1055</b> M			
3. SEX <b>FEMALE</b>		4. RACE <b>NEGROID</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 1, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD.</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1827 Chilton St. 21218</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>THOMAS CLARY</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ADDIE BONNER</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>247-12-9141</b>		17. INFORMANT ADDRESS <b>Edith Bennett 1827 Chilton St.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>Massive brainstem infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c)								12 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>3/8</b> , 19 <b>85</b> , to <b>3/20</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>3/20</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Bernita C. Taylor</b>					DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>3/20/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Bernita C. Taylor</b>					22e. ADDRESS <b>Union Memorial Hospital</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>			23b. DATE <b>3-23-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Sinai Bpht Ch.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>GAFFNEY S.C.</b>		
24. FUNERAL DIRECTOR NAME <b>Calvin B. Scruggs</b>					25a. DATE REC'D. BY REGISTRAR <b>MAR 22 1985</b>				
ADDRESS <b>1412 E. Preston</b>					REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO HONORABLE DIRECTOR: After this certificate has been used by the attending physician and completely filled in by the funeral director, please send it to the Bureau of Burial, 1000 Broadway, New York 17, New York, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 2 is marked as Item 18 shows any injury or other traumatic event, the medical examiner must be involved.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medication should be held and the patient should be referred to the physician.

### MEDICAL CERTIFICATION

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 2 0 9

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CLEMMIE</b>		FIRST <b>Steward</b> MIDDLE <b>WATSON</b> LAST		2a. DATE OF DEATH MONTH <b>3</b> DAY <b>24</b> YEAR <b>85</b>		2b. HOUR <b>5:15</b> AM <b>A</b>	
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>Dec</b> DAY <b>6</b> YEAR <b>1922</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Georgia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VAMC, Baltimore, Maryland 21218</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Cook Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>D.C. Childrens Center</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Md.</b>		13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Severn</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>James Benjamin</b> MIDDLE <b>Watson</b> LAST		15. MOTHER'S MAIDEN NAME FIRST <b>Giddie</b> MIDDLE <b>Mae</b> LAST <b>Morris</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>252-18-8086</b>	
17. INFORMANT ADDRESS <b>Mrs. Otero L. Watson/wife/same as 13e</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASPIRATION/PNEUMONIA</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <b>CEREBRAL INFARCTION</b>		(c) <b>MYOCARDIAL INFARCTION</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>CONTRIBUTING TO DEATH</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <b>March 11</b> , 19 <b>85</b> , to <b>March 24</b> , 19 <b>85</b> , that (we) last saw the deceased alive on <b>March 24</b> , 19 <b>85</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did not) view the body after death.							
22b. SIGNATURE <b>Tim Jack M.D.</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/25/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Tim Jack M.D.</b>		22e. ADDRESS <b>VAMC, Baltimore, Maryland 21218</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-29-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cheltenham</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cheltenham, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>John T. Rhines Co.,</b> ADDRESS <b>3015 12th ST. N.E.</b>		25a. DATE REC'D. BY REGISTRAR <b>20017</b>		25b. REGISTRAR'S SIGNATURE <b>Lelia Davidson-Randall</b>			

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Tom Jack & P.  
Tom Jack M.D.

MAR 11 1957



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 2 1 0

REG. NO.

1- FOR  
STATE  
REGISTRAR

082028

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH				MONTH	DAY	YEAR	2b. HOUR	
HARRY T. WATSON					03-02-85							1:45P M	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS.		
M	B		2 2 84		99 YRS.				MONTHS		DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Virginia		USA				Baltimore City, MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		LUTHERAN HOSPITAL											

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Maryland		Baltimore		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1510 N. Pulaski St. 21217	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST John Henry Watson				FIRST MIDDLE LAST Annie Major					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO		217-32-9796		Jessie E. Ruffin 1510 N. Pulaski St.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) Bilateral CVA			
DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
(b) Metabolic encephalopathy			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) (this hospital) attended the deceased from 02-25, 19 85, to 03-02, 19 85, that (b) (we) lost saw the deceased alive on 03-02, 19 85, and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did not) view the body after death.		22b. SIGNATURE Sissay Awoke		DEGREE MD.		22c. DATE SIGNED 03-02-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SISSAY AWOKE		22e. ADDRESS Jullum Hospital					

23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL		3/8/85		Arbutus Mem. Pk.		Arbutus, COUNTY Md. STATE	

24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wm C March F/H Inc. 1101 E North Avenue		MAR 4 1985		E. Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

200720



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and an autopsy will be required.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8508211

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST OTIS	MIDDLE	LAST WATSON SR.	2a. DATE OF DEATH MONTH DAY YEAR 03 27 85		2b. HOUR 7 <sup>21</sup> M	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 02 - 07 - 22		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) LEWISTON, N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD		
10. CITY OR TOWN OF DEATH BALTIMORE CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Albert Watson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LALLA CLARK		13e. STREET ADDRESS / ZIP CODE 1632 32nd STREET 21218				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 220-01-7430		17. INFORMANT ADDRESS MARGIE WATSON 1632 32nd ST.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRAINSTEM INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: H/O Brainstem infarcts X2								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I (this hospital) attended the deceased from 3/22 1985, to 3/27 1985, that (I (we) last saw the deceased alive on 3/27 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did (did not) view the body after death.								
22b. SIGNATURE Robert A. Miller MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/27/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT MILLER				22e. ADDRESS UNION MEMORIAL HOSPITAL				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4-1-85		23c. NAME OF CEMETERY OR CREMATORY CROWNSVILLE VA.		23d. LOCATION CITY OR TOWN COUNTY STATE CROWNSVILLE MD		
24. FUNERAL DIRECTOR NAME BROWN/THOMPSON F. H				ADDRESS 1913 W. BALTO. ST. #6		25a. DATE REC'D. BY REGISTRAR 1985		
				25b. REGISTRAR'S SIGNATURE [Signature]				

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08212

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Norene N. Watts				2a. DATE KNOWN OF DEATH ESTIMATED 3/ 18/ 1985				2b. HOUR 10:39	
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 10 11 1927	6. AGE (IN YEARS) LAST BIRTHDAY 57 YRS.	IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 3/ 18/ 1985	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2000 O'Dell Ave., #1318				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales lady		12b. KIND OF BUSINESS OR INDUSTRY Lucas Bros.	
13a. STATE Maryland				13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 2000 Odell Avenue Baltimore, Maryland 21237		
14. FATHER'S NAME FIRST MIDDLE LAST Howard Newton				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Newton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No.		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 217-22-5991		17. INFORMANT 717 Druid Hill Pk. Lake Dr James R. Watts Baltimore, Maryland 21217			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Arteriosclerotic Hypertensive Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b). DUE TO, OR AS A CONSEQUENCE OF (c).									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic Alcoholism									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 3/19/85	
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.				ADDRESS 111 Penn St.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/23/1985		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Nutter & Sons 2501 Gwynns Falls Parkway Funeral Home, Inc. Baltimore, Maryland 21216				25a. DATE REC'D. BY REGISTRAR MAR 20 1985		25b. REGISTRAR'S SIGNATURE 			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))



REC'D MC-100-200

APR 1964

RECEIVED  
MAY 1964

RECEIVED  
MAY 1964

RECEIVED  
MAY 1964


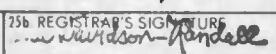


STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

008213

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST TYRONE			MIDDLE G.			LAST WATTS			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR <input checked="" type="checkbox"/> 3 14 19 85			2b. HOUR M 9:25 P		
3. SEX male		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 8 1 60		6. AGE (IN YEARS) LAST BIRTHDAY 24 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 14 19 85			2d. HOUR M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland				13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2315 Robb Street 21218							
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Watts, Sr.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blossie Hutchinson											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Thomas Watts Sr. 2315 Robb Street									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Stab wound of thorax</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b). DUE TO, OR AS A CONSEQUENCE OF (c).														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR <u>7:15</u> P.M. MONTH DAY YEAR <u>3-14-1985</u>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject stabbed.									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1220 Darley Ave., Balto. Md.									
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 3-15-85									
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201													
23a. BURIAL, CREMATION, REMOVAL BURIAL				23b. DATE 3/20/85		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co, Md.							
24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H, Inc. 1101 E North Ave				25a. DATE REC'D. BY REGISTRAR MAR 18 1985				25b. REGISTRAR'S SIGNATURE 									

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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2012 COLTON LIBER

WELFARE BOARD



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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ELIZABETH E. WAYS</b>			2a. DATE OF DEATH MONTH <b>3</b> DAY <b>28</b> YEAR <b>85</b>		2b. HOUR <b>6:30 P M</b>
3 SEX <b>female</b>	4 RACE <b>white</b>	5. DATE OF BIRTH MONTH <b>3</b> DAY <b>28</b> YEAR <b>08</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10 CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Medical Tech.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Health</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Catonsville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>37 Bloomsbury Ave. 21228</b>
14. FATHER'S NAME FIRST <b>Edward</b> MIDDLE <b>A.</b> LAST <b>Poehlmann</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Annie</b> MIDDLE <b>Seidel</b> LAST <b>Seidel</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-05-8266</b>		17 INFORMANT ADDRESS <b>316 Lee Drive</b> <b>Mr. Norman E. Poehlmann Balt., Md 21228</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>massive gastrointestinal hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>hemorrhagic gastritis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Metastatic carcinoma of the gallbladder</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>hours</b> <b>years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <b>0</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>3/22</b> , 19 <b>85</b> , to <b>3/28</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>3/28</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Steven H. Pearlman</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>3/29/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Steven H. Pearlman, M.D.</b>		22e. ADDRESS <b>St. Agnes Hospital, 900 Caton Ave.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/1/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MountView Cemetery</b>	
24. FUNERAL DIRECTOR NAME <b>MacNabb Funeral Home</b>		ADDRESS <b>Catonsville, Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Marriottsville Howard Md.</b>	
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>APR 1 - 1985</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filing in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be placed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

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(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the event.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8215	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen Mae WAZNIAK			2a. DATE OF DEATH MONTH DAY YEAR 3 / 26 / 85		2b. HOUR 10 <sup>50</sup> PM
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 4 20 1920		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD		10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS 3638 WATER TANK RD. 21102	
13b. STATE Maryland		13c. COUNTY Carroll		13d. CITY OR TOWN Manchester	
14. FATHER'S NAME FIRST MIDDLE LAST Harry Rimbach		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Younghaus		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16b. SOCIAL SECURITY NO. 21707 9769		17. INFORMANT John J. WAZNIAK		ADDRESS 3638 Water Tank Rd Manchester, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Progressive Neurologic failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>20 Hodgkin's disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/10/1985</u> , to <u>3/26/1985</u> , that (I) (we) lost saw the deceased alive on <u>3/26/1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE W. Jaziri		DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Walid A. JAZIRI		22e. ADDRESS Good Samaritan Hospital			
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) Burial		23b. DATE Mar. 29, 1985		23c. NAME OF CEMETERY OR CREMATORY Evergreen Mem. Gar	
23d. LOCATION CITY OR TOWN Finksburg Carroll Md.		23e. DATE REC'D. BY REGISTRAR			
24. FUNERAL DIRECTOR NAME H. E. Ebbhardt		ADDRESS Manchester, Md.		25. DATE REC'D. BY REGISTRAR MAR 28 1985	
25. REGISTRAR'S SIGNATURE J. E. Ebbhardt					

0804-20

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
PETER S. WEAVER		MARCH 28, 1985		10:55 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. IF UNDER 1 YEAR	
Male	White	Sept. 16, 1943	41	MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH		
Florida	U.S.A.	NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY
BALTIMORE	JOHNS HOPKINS HOSPITAL		President		Wickes-Barre Clay Products Co.
13a. USUAL RESIDENCE	13b. CITY OR TOWN	13c. INSIDE CITY LIMITS?	13d. STREET ADDRESS / ZIP CODE		13e. STREET ADDRESS / ZIP CODE
Penna. Luzerne	Dallas	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Box 235 Briarcrest Rd. Rt 1		18612
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
H. Robert Weaver		Margaret Shindel			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		173-36-9000		Carol Ann Weaver (wife) Same as # 13	
18. CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) SEPSIS					1 wk
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					1 wk
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: HEPATIC FAILURE, RENAL FAILURE, GASTROINTESTINAL HEMORRHAGE					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
2/22/85	CHRONIC MYELOGENOUS LEUKEMIA	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED			
(IF EITHER, NOTIFY MEDICAL EXAMINER)	HOUR A.M. MONTH DAY YEAR	(ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
	P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY	21f. LOCATION			
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from FEB 11, 1985, to MAR 28, 1985, that (we) last saw the deceased alive on MAR 28, 1985, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (do) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
MICHAEL SETH DOMENICK		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		3/20/85	
22d. PHYSICIAN'S NAME		22e. ADDRESS			
MICHAEL SETH DOMENICK		FRANCIS SCOTT KEY MEDICAL CENTER			
23a. BURIAL, CREMATION, REMOVAL	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Burial	4/1/85	Mt. Greenwood Cem.	Trucksville, Luzerne Co., Pa.		
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
E. Barnes Fleming Funeral Service		MAR 29 1985			





078007

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>BESSIE O. WEBB</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 / 15 / 85</b>			2b. HOUR <b>9:27 P.M.</b>			
3. SEX <b>F</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10-18-1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Litheran Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Nurses Aid</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
13a. STATE <b>Md.</b>			13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>James L. Webb</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rebecca</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>217-30-4382</b>			17. INFORMANT ADDRESS <b>Mrs. Margaret H. Hoffnagel</b>			8710 Wendell Ave. <b>Balto. Md.-21234</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Hemoptysis</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>1. Fracture of hip</b>									
19a. DATE OF OPERATION <b>3/13/85</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Fracture Left Hip</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>			
22a. I certify that (I) (this Hospital) attended the deceased from <b>3/13/85</b> 19 <b>85</b> to <b>3/15</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>3/13/85</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not view the body after death).									
22b. SIGNATURE <b>John C. Miller</b>			DEGREE			22c. DATE SIGNED <b>3/15/85</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ARNISUE NO</b>	
22e. ADDRESS <b>730 Ashburton St. Baltimore</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3-18-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>John C. Miller Inc-6415 Belair Rd.-21206</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 18 1985</b>			
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



080091

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>NAOMI F. WEBER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3-16-85</b>			2b. HOUR <b>7:45 PM</b>			
3. SEX <b>Female</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2/24/23</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Capitol Heights, Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>			12a. USUAL OCCUPATION (IF DECEASED) <b>Telephone Operator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>C&amp;P Telephone</b>	
13a. STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. STREET ADDRESS / ZIP CODE <b>5502 Hamlet Ave. 21214</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Raymond S. Hunt</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna M. Unknown</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>219-12-2907</b>		17. INFORMANT ADDRESS <b>Edward Forney, RD3, Box 439, Glen Rock, Pa.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atrial fibrillation E R/V R, chronic + resistant to tx</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>COPD</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>17327</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <b>Fever, etiology unknown</b>									
19a. DATE OF OPERATION <b>Now</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>2/15</b> , 19 <b>85</b> , to <b>3/16</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>3/16</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Melissa Friedland, MD</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3/16/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MELISSA FRIEDLAND</b>			22e. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3/20/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., Md.</b>		
24. FUNERAL DIRECTOR <b>Schmunk Funeral Home, Inc.</b> 3331 Brehms Lane, Balto., Md. 21213						25a. DATE REC'D. BY REGISTRAR <b>MAR 19 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Wardson-Henderson</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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RECEIVED

BALTIMORE CITY

UNION MEMORIAL HOSPITAL

BALTIMORE

RECEIVED

IN A BOX FOR THE EYE CLINIC IN BALTIMORE

RECEIVED

RECEIVED

25.15

UNION MEMORIAL HOSPITAL

RECEIVED

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, REAS-  
 EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.  
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS  
 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,  
 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

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DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 08219	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CLARENCE Eli WEBSTER</b>										20. DATE KNOWN OF DEATH MONTH DAY YEAR <b>3-23-85</b>	
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>2/24/06</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>76</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		21. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>4-2-85</b>		22. HOUR <b>8PM</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Iowa</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3301 Greenmount Avenue</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Meat Cutter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retail</b>			
13a. STATE <b>MD</b>		13b. COUNTY <b>Balto.</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3301 Greenmount Ave.,</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Walter Hinton Webster</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nina Pearl Hensley</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		(IF YES, GIVE WAR OR DATES) <b>WW II</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Paul Teleen, Colorado</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Margarita A. Korell</i>		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER						DATE SIGNED <b>4-3-85</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>		ADDRESS <b>111 Penn Street</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>4/4/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., MD</b>					
24. FUNERAL DIRECTOR NAME <b>Henry W. Jenkins &amp; Sons Co.</b>				ADDRESS <b>4905 York Road Balto., MD 21212</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 4 1985</b>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randell</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. The funeral director should remove carbon papers, pages 1 and 2, and should be notified in 72 hours after death with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 5 0 8 2 2 0	
1 - FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE & PRINT) (IRVIN) IRVING K. WEBSTER, SR.		2a. DATE OF DEATH MARCH 21, 1985		2b. HOUR 12:54A M	
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 1-22-1916	6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RIGGER	12b. KIND OF BUSINESS OR INDUSTRY STEEL Co.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.	13b. COUNTY BALTO.	13c. CITY OR TOWN BALTO.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 507 N. LUZERNE AVE. 21205	
14. FATHER'S NAME FIRST MIDDLE LAST ARTIE WEBSTER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RITA WEBSTER.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	16b. SOCIAL SECURITY NO. W.W. II 213-12-9978	17. INFORMANT ADDRESS Mrs. Elizabeth M. Webster - 507 N. Luzerne Ave. 21205			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electromechanical dissociation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Tension pneumo (corrected), pump failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Presumptive massive MI</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>COPD</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3-21</u> 19 <u>85</u> , to <u>3-21</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3-21</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>H. Steiner</u>		DEGREE MD		22c. DATE SIGNED <u>3-21-85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>STEINER</u>		22e. ADDRESS <u>Johns Hopkins Hosp</u> 600 N. WOLFE ST. BALTO. MD 21205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	23b. DATE <u>3-25-85</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MEADOWRIDGE CEM.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>BALTO. MD</u>	
24. FUNERAL DIRECTOR NAME <u>Jefferson St.</u>		25a. DATE REC'D. BY REGISTRAR <u>MAR 26 1985</u>		25b. REGISTRAR'S SIGNATURE <u>Peter Davidson-Randall</u>	

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ALTA H. CLAYTON

ALTA H. CLAYTON

W. M. 1-22-1916

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Raymond G. Webster			2a. DATE OF DEATH MONTH DAY YEAR March 13, 1985			2b. HOUR 3:58 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 3, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital of Maryland				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman		12b. KIND OF BUSINESS OR INDUSTRY Bureau of Highways	
13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Henry Webster			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Klein			13e. STREET ADDRESS / ZIP CODE 3537 Buena Vista Avenue 21211			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218 10 8387		17. INFORMANT Virginia Poe		17. ADDRESS 1013 W 37th Street 21211			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Decubitus ulcer. SP. skin muscle</u> DUE TO, OR AS A CONSEQUENCE OF <u>Rotation flap</u> (b) <u>chronic non healing decubitus</u> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7/25/85</u> <u>3 months</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Urinary tract infection</u>									
19a. DATE OF OPERATION <u>2/25/85</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ulcer</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NO WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>2/11</u> 19 <u>85</u> to <u>3/13</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3/13</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Amatun N. Haem</u>				DEGREE MD				22c. DATE SIGNED 3/13/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AMATUN N. HAEEM				22e. ADDRESS 501 Dolphin street Balto MD 21217					
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE 03/16/1985		23c. NAME OF CEMETERY OR CREMATORY Lake View Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Carroll Co., Maryland			
24. FUNERAL DIRECTOR NAME Burge-Henss Funeral Home, Baltimore, Md. 21211				25a. DATE REC'D BY REGISTRAR MAR 15 1985		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <del>Elizabeth</del> <b>EDNA Mae Weiler</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>March 27, 1985</b>		2b. HOUR M <b>AM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 2, 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Mercy Hosp. Balto. d.</b>		12a. USUAL OCCUPATION (TYPE WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William ----- Boyle</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nora ----- Penn</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO <b>218-03-0250</b>		17. INFORMANT ADDRESS <b>Doris M. Weiler, Same as above</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>March 27, 19 85</b> to <b>March 27, 19 85</b> , that (I) (we) last saw the deceased alive on <b>March 27, 19 85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>William Waschler MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/27/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WILLIAM WASCHLER</b>				22e. ADDRESS <b>MERCY HOSP</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Mar. 30, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>McCutty Funeral Home, 130 E. Port Ave. Balto. Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 29 1985</b>			

MEDICAL CERTIFICATION

29

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DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



The following information was obtained from the records of the  
 Department of the Interior, Bureau of Land Management, on  
 the subject of the land described in the foregoing  
 instrument, to-wit:

The land described in the foregoing instrument is situated  
 in the County of \_\_\_\_\_, State of \_\_\_\_\_, and is  
 more particularly described as follows:

The land described in the foregoing instrument is situated  
 in the County of \_\_\_\_\_, State of \_\_\_\_\_, and is  
 more particularly described as follows:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

092024

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM F. WEISAND SR.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>03 24 85</b>			2b. HOUR <b>1:25P M</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>09 29 05</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4003 MORTIMER AVENUE</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MACHINE OPERATOR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>WESTINGHOUSE</b>	
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>--</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNAVAILABLE</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNAVAILABLE</b>			16. SOCIAL SECURITY NO. <b>215-05-6847</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>			17. INFORMANT ADDRESS <b>21229</b>			17. WILLIAM F. WEISAND, JR. 4027 WILKENS AVE.			
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY INSUFFICIENCY</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>EMPHYSEMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>INACTIVE PULMONARY TB</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 MOS</b> <b>10 YEARS</b> <b>UNKNOWN</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NO) (BY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>FEB 85</b> , to <b>FEB 85</b> , the (I) (we) last saw the deceased alive on <b>FEB 85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Jack E. Nissim M.D.</b>			22c. DEGREE <b>M.D.</b>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <b>3/26/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JACK E. NISSIM, M.D.</b>			22e. ADDRESS <b>2435 W. BELVEDERE AVENUE</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>03-28-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>		
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b>			24. ADDRESS <b>4107 WILKENS AVE.</b>			25. DATE RECEIVED BY REGISTRAR <b>APR 8 1985</b>		26. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

BP





077090

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8508224

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CLEONE OSCAR WELLER			2a. DATE OF DEATH MONTH DAY YEAR MARCH 11, 1985			2b. HOUR 18 55 PM				
3. SEX male		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MARCH 13, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 11		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		9b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MAINTANANCE		12b. KIND OF BUSINESS OR INDUSTRY SPARROWS PT. BETH STEEL		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY ANN ARUNDEL 13c. CITY OR TOWN GLEN BURNIE 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						13e. STREET ADDRESS / ZIP CODE 517 HAMLEN RD 21061				
14. FATHER'S NAME FIRST MIDDLE LAST OSCAR H. WELLER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALICE L. HOWER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES WWII		16b. SOCIAL SECURITY NO. 184.12.1088		17. INFORMANT (WIFE) MRS. ROSE M. WELLER		ADDRESS SAME AS 13				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) SQUAMOUS CELL LUNG DUE TO, OR AS A CONSEQUENCE OF (c) METASTATIC Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 1 MONTH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a SPINAL CORD COMPRESSION										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from Feb 1, 1985, to Mar 11, 1985; that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE J. C. Downs				DEGREE				22c. DATE SIGNED 3/11/85		
22d. PHYSICIAN NAME (TYPE OR PRINT) J. C. Downs				22e. ADDRESS UMCC / 22 SO. GREENE ST / BALTIMORE						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MARCH 15, 1985		23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE ELK RIDGE, MD.				
24. FUNERAL DIRECTOR NAME ADDRESS SINGLETON FUNERAL HOME GLEN BURNIE, MD. 21061				25a. DATE REC'D. BY REGISTRAR MAR 14 1985		25b. REGISTRAR'S SIGNATURE C. Davidson-Randall				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be buried with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy performed.

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN A COPY OF YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

082029

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 08225	
1- FOR STATE REGISTRAR										2a DATE KNOWN OF DEATH	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST George K. West										XX MONTH DAY YEAR 3-8 19 85	
3 SEX Male		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR Oct 11, 1925		6 AGE (IN YEARS) LAST BIRTHDAY 59 YRS.		IF UNDER 1 YR. MONTHS DAYS		2c DATE PRONOUNCED DEAD MONTH DAY YEAR 3-8 19 85	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va				7b CITIZEN OF WHAT COUNTRY? U.S.A.				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10 CITY OR TOWN OF DEATH Baltimore				11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2029 N. Fulton Avenue				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer-----0-----		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE Md											
13b COUNTY None											
13c CITY OR TOWN Baltimore											
13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
13e STREET ADDRESS 2029 Funlton Ave. 21217											
14 FATHER'S NAME FIRST MIDDLE LAST Schofield West											
15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sterling Coleman											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) -----0-----				16b SOCIAL SECURITY NO. 228-24-6264				17 INFORMANT ADDRESS Mary Tucker, 3450 Reistertown Rd. 21215			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Alcoholism and <del>XXXXXXXXXXXXXXXXXXXX</del> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Seizure Disorder DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 3-9-85			
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 1				23b DATE 3/13/85		23c NAME OF CEMETERY OR CREMATORY Mt Auburn Cemetery				23d LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24 FUNERAL DIRECTOR NAME Law Funeral Home 4611 Park Heights Ave. 21215				25a DATE REC'D. BY REGISTRAR MAR 12 1985				25b REGISTRAR'S SIGNATURE 			

20% COTTON YARN

5/16

10/16



088141

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO. 08226

1. DECEASED NAME (TYPE OR PRINT) <b>JOHN Stanley WEST, JR.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>03 25 85</b>			2b. HOUR <b>2:10 P.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5-26-39</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>46</b> YRS.		7. UNDER 1 YEAR MONTHS DAYS <b>46</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>city</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bon Secours Hospital Balt.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sod Layer</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE CITY OR TOWN <b>MD CARROLL SYKESVILLE</b>					13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE <b>518 Schoolhouse Rd. 21784</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Stanley West, Sr.</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Esther Savoy</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT ADDRESS <b>Eugene Johnson Sykesville, MD 578 Schoolhouse Rd.</b>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Terminal Cancer,**

DUE TO, OR AS A CONSEQUENCE OF

**primary unknown**

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH DEAD BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>3/8</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>3/25 1985</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>3/25</b> 19 <b>85</b> , to <b>3/25</b> 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>3/25</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Kuang-yen Huang</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>3/25/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KUANG-YEN HUANG</b>				22e. ADDRESS <b>BON Secours Hospital</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-28-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LAKEVIEW CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SYKESVILLE CARROLL MD</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Harry W. Haight Sykesville, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 26 1985</b>			
				25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

BP



088046

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Nimrod</b>		MIDDLE <b>(Westcott)</b>		LAST <b>WESTCOTT</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>03 23 85</b>		2b. HOUR <b>12:50 PM</b>		
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 5 29</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY, MD.</b>				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FRANCIS SCOTT KEY MEDICAL CTR.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>			13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>2132 O'Dell Avenue 21237</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Nimrod Westcott, Sr.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margie Brown</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Unknown</b>		16b. SOCIAL SECURITY NO. <b>213-26-8423</b>		17. INFORMANT ADDRESS <b>Margie Jordan 1506 N. Rutland Avenue</b>						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiopulmonary arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **Subdural Hematoma**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

**24h**

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION <b>3/22/85</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Subdural Hematoma</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR AM MONTH DAY YEAR <b>1 P.M. 3-20-85</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>Subject fell.</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>street</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>2132 O'Dell Ave. Balto. Md.</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>3/22</b> 19 <b>85</b> to <b>3/23</b> 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>3/23</b> 19 <b>85</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Bruce Mottet</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/23/85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Bruce Mottet</b>		22e. ADDRESS <b>Francis Scott Key Medical Center</b>					

23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>3/30/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		23d. LOCATION <b>Baltimore, Md. STATE</b>	
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24. FUNERAL DIRECTOR NAME <b>Wm C March F/H Inc. 1101 E North Avenue</b>		25. DATE REC'D. BY REGISTRAR <b>MAR 26 1985</b>		25. REGISTRAR'S SIGNATURE <b>John Davidson</b>	
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



REPRODUCTION OF THIS DOCUMENT IS PROHIBITED

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>(aka Earl)</b>		FIRST <b>EARLE</b>		MIDDLE <b>E.</b>		LAST <b>WESTLUND</b>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>3-1-85 19</b>		2b. HOUR <b>M</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 6, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD <b>3-1-85 19</b>		7d. HOUR <b>5:14P</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Conn.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <b>Good Samaritan Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Auditor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Savings Bank</b>			
13a. STATE <b>Conn.</b>		13b. COUNTY <b>New Haven</b>		13c. CITY OR TOWN <b>West Haven</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>18 Atwood Ave. 06516</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry Westlund</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bessie Hartrey</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		(IF YES, GIVE WAR OR DATES) <b>None</b>		16b. SOCIAL SECURITY NO. <b>049-07-6068</b>		17. INFORMANT (wife) ADDRESS <b>Mrs. Roszan A. Westlund Same as #1</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Margarita A. Korell</b>				TITLE (SPECIFY) <b>M.D. Assistant</b>				DATE SIGNED <b>3-2-85</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn Street</b>							
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>Burial</b>		23b. DATE <b>3/5/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Westport Fairfield Conn.</b>			
24. FUNERAL DIRECTOR NAME <b>E. Barnes</b>				ADDRESS <b>Fleming Funeral Service- Benson, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 4 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Jana Davidson-Randall</b>	

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MADE IN AFRICA



RELEASED AS NON-MED PER MR. DAVIS/DR. KAUGHMAN FROM MEDICAL EXAMINER

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>DALLAS L. WESTON</b>			2a. DATE OF DEATH MONTH <b>MARCH</b> DAY <b>27</b> YEAR <b>1985</b>		2b. HOUR <b>8:32<sup>M</sup></b>	
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH <b>8</b> DAY <b>22</b> YEAR <b>1921</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>
7a. BIRTHPLACE (COUNTRY) <b>Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Chauffeur</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Dept. of Water Works</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>Dallas</b> LAST <b>Weston</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Elizabeth</b> MIDDLE <b>Gatling</b> LAST <b>Gatling</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>	17. INFORMANT <b>Elizabeth Sawyer</b>	701 N. Arlington Ave. Apt. <b>405 Baltimore, Md. 21217</b>		

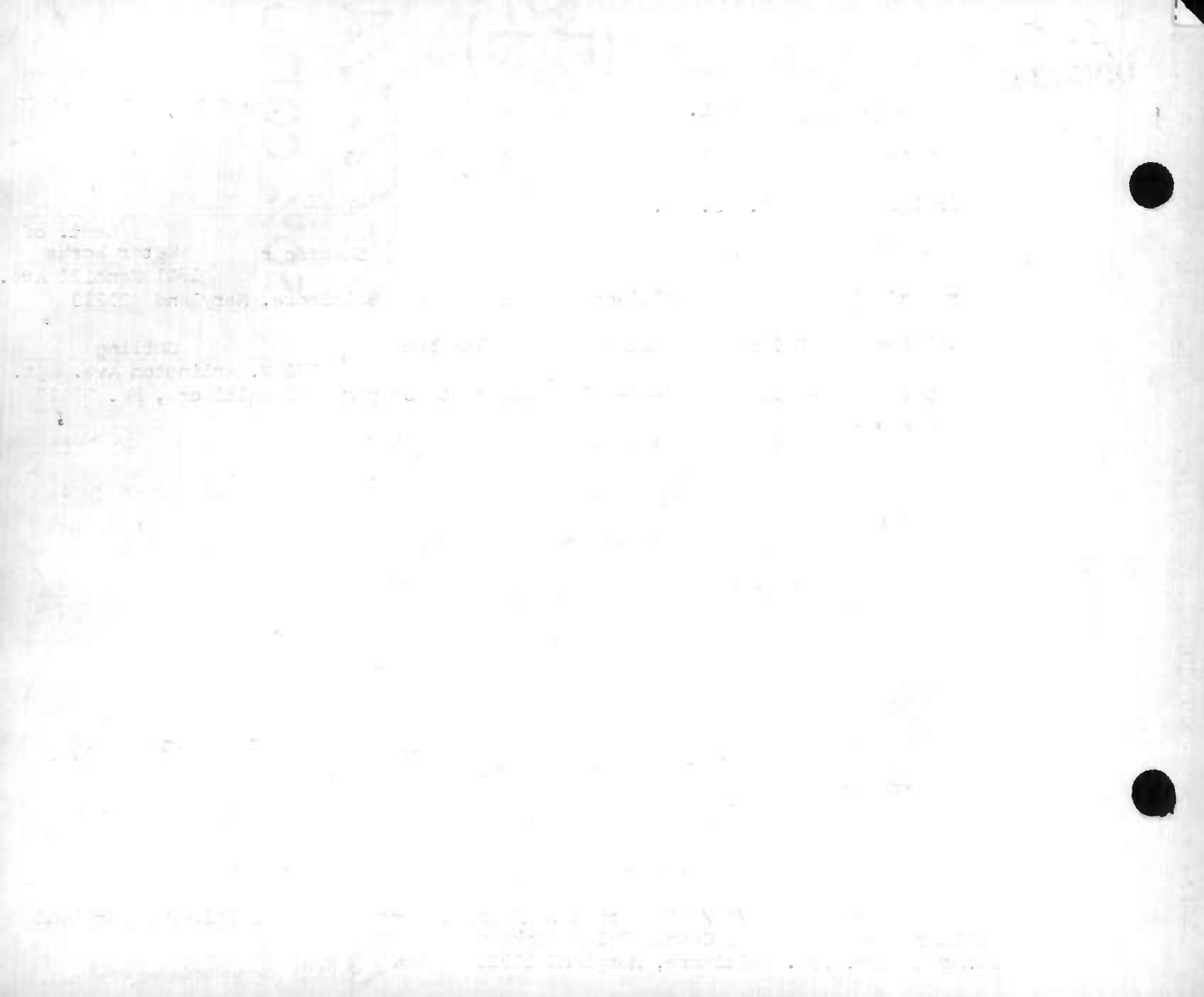
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 mins</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Seizure</b>		<b>35 mins</b>
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Probable hypoxia</b>		<b>1 hour</b>

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c)  
**Lung cancer**

19a. DATE OF OPERATION <b>3/27</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Lung cancer</b>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>3/27</b> , 19 <b>85</b> , to <b>3/27</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>3/27</b> , 19 <b>85</b> , and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Paul Katzenstein</b>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>3/27/85</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PAUL KATZENSTEIN</b>		22e. ADDRESS <b>Johns Hopkins Hospital</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>3/30/1985</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>	23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE <b></b>
24. FUNERAL HOME TO WHICH REMAINS WERE DELIVERED NAME <b>Nutter &amp; Sons</b> ADDRESS <b>2501 Gwynns Falls Parkway</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 29 1985</b> 25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with 77 State Office with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>MINERVA MADELINE WHALEN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>03-07-85</b>			2b. HOUR <b>9<sup>05</sup> A M</b>				
3. SEX <b>FEMALE</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>05 08 04</b>		6. AGE (IN YEARS EAST BIRTHDAY) <b>80</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Meridian-City Manor</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PACKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>DYE CRAFT</b>		
13a. STATE <b>MD.</b>			13b. COUNTY <b>--</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alfred A. Handley</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Gertrude Purdy</b>			13e. STREET ADDRESS / ZIP CODE <b>2664 WILKENS AVENUE, 21223</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>214-14-8431</b>		17. INFORMANT <b>DOROTHY PINER</b>				ADDRESS <b>500 MIRABILE LANE, 21214</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **CARDIAC ARREST**

DUE TO, OR AS A CONSEQUENCE OF

(b) **A.S.C.V.D.**

DUE TO, OR AS A CONSEQUENCE OF

(c)

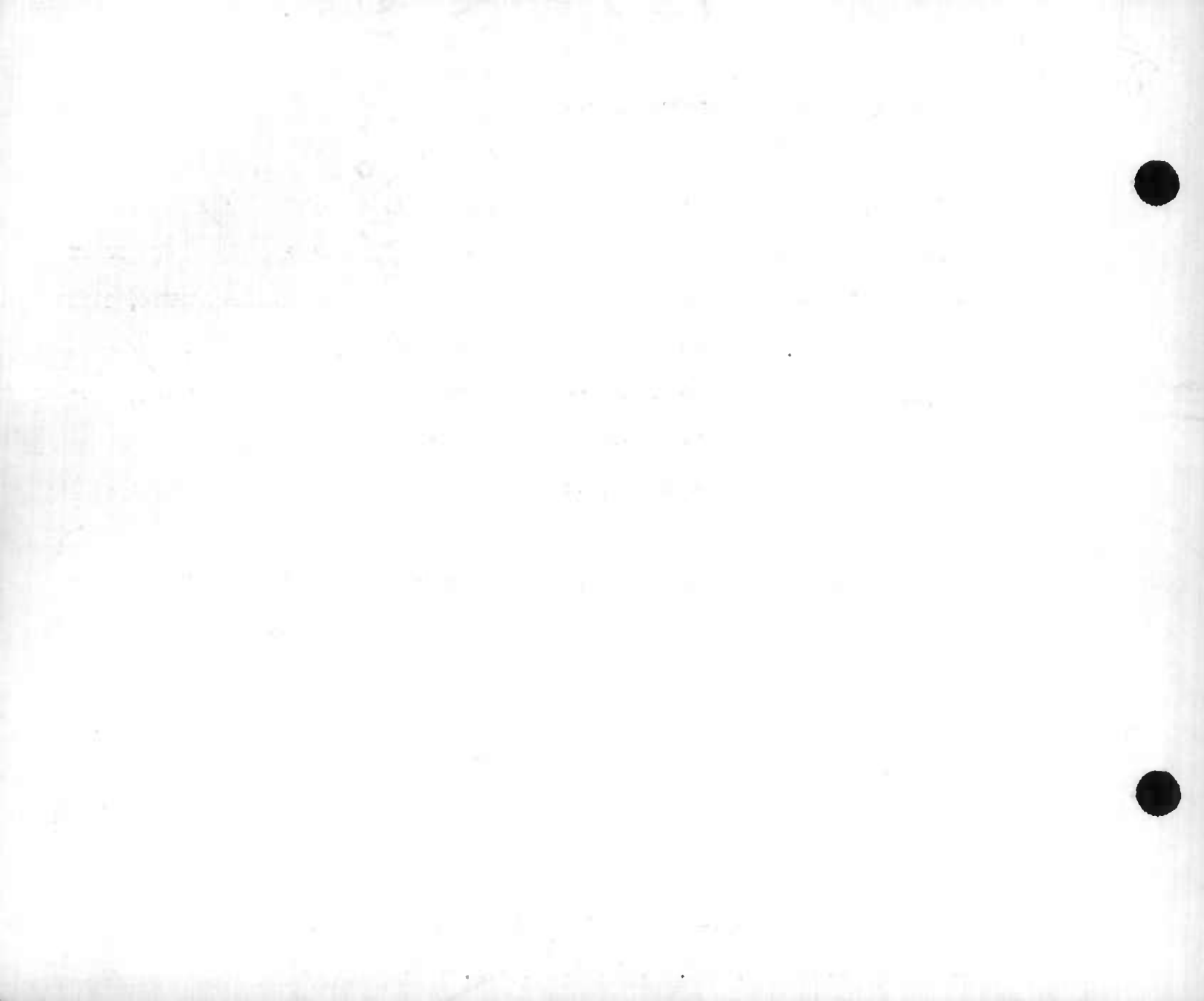
APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**PULMONARY FIBROSIS, CRIPPLING OSTEOARTHRITIS, DEMENTIA**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>2/12/85</b> to <b>2/7/85</b> , that (I) (we) last saw the deceased alive on <b>3/04/85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>K.D. HARMASENA</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3/07/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K.D. HARMASENA</b>				22e. ADDRESS <b>48, 16th AVE. BALTO. Md 21225</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>03-11-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>	
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b>				ADDRESS <b>4107 WILKENS AVE.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 11 1985</b>	
				25b. REGISTRAR'S SIGNATURE <b>Gula Davidson-Randall</b>			





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 2 3 1

FOR  
STATE  
REGISTRAR  
HARRY B. WHALEY

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HARRY B. WHALEY			2a. DATE OF DEATH MONTH DAY YEAR 3 2 85			2b. HOUR 7: 30 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 25 1904		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	
						12b. KIND OF BUSINESS OR INDUSTRY Musician	
13a. STATE Maryland				13b. COUNTY -		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST Harry B. Whaley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Reed			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2		17. INFORMANT 3838 S Roland Avenue Apt 509 Elizabeth Carlton Baltimore, Md. 21211			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>End stage heart failure with bilateral effusion</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ischemic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sepsis / Acute renal failure</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>None</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2/19, 1985</u> to <u>3/2</u> , 19 <u>85</u> , that (we) lost saw the deceased alive on <u>3/2, 1985</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Arthur</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DR. P. IMAM</u>				22e. ADDRESS St. Agnes Hospital, Baltimore, md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/5/85		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, Md. 21228				25a. DATE REC'D BY REGISTRAR MAR 4 1985		25b. REGISTRAR'S SIGNATURE <u>Davidson-Randall</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DHMH - 16 50M 4/83  
(VRA 15, 4)1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EMILY J. WHARTON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3-16-85</b>		2b. HOUR MIN. <b>9:15 A M</b>
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9 7 1903</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>KESWICK</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry H. Johnson</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Fannie E. Williams</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No.</b>		16b. SOCIAL SECURITY NO. <b>190-20-3232</b>	17. INFORMANT ADDRESS <b>Hermione Wharton 2019 Division Street Baltimore, Md. 21217</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>COPD</b>					<b>10 YRS</b>
DUE TO, OR AS A CONSEQUENCE OF (c) <b>HASCD</b>					<b>10 YRS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (he) (this hospital) attended the deceased from <b>NOV-11</b> , 19 <b>83</b> , to <b>MAR-16</b> , 19 <b>85</b> , that (he) (we) lost saw the deceased alive on <b>MAR-16</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>John F. Hartman, M.D.</b>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3-16-85</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN F. HARTMAN</b>			22e. ADDRESS <b>KESWICK-700 W. 40th St. 21211</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>3/20/1985</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S NAME <b>Nutter &amp; Sons</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 20 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John F. Hartman</b>	
24. FUNERAL HOME, INC. NAME <b>Funeral Home, Inc. Baltimore, Maryland</b>		25a. ADDRESS <b>2501 Gwynns Falls Parkway Baltimore, Maryland 21216</b>		25b. SIGNATURE <b>John F. Hartman</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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En l'absence, pour l'Etat

3/20/1985 Atlanta Memorial Park

Index

Walter E. Scott, 5201 Gwynne, Baltimore, Maryland 21206

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Alice L. Wheeler</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>March 26, 1985</i>		2b. HOUR M <i>AM</i>							
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>May 11, 1906</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>78</i>		7. UNDER 1 YEAR MONTHS DAYS <i>0 0</i>		8. UNDER 24 HRS. HOURS MIN. <i>00 00</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.						
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>4102 West Bay Court</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Homemaker</i>				
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>4102 West Bay Court, 21225</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Calvin Arnold</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Dessie</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>214-03-1236</i>		17. INFORMANT ADDRESS <i>Robert L. Wheeler Same as #13</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular arrest</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i>		
DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASAC. Chronic C.H.F. M.R.</i>										<i>Years.</i>		
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>3176 Baltimore, A. A. Co., Md.</i>							
22a. I certify that (I) (this hospital) attended the deceased from <i>12/1</i> 19 <i>75</i> to <i>3/26</i> 19 <i>85</i> , that (I/we) last saw the deceased alive on <i>3/23</i> 19 <i>85</i> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>H. F. Lawrence</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>3/26/85</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Lawrence F. Auxalt, M.D.</i>					22e. ADDRESS <i>3001 South Harover St., Balto., Md. 21230</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>3/29/1985</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, A. A. Co., Md.</i>					
24. FUNERAL DIRECTOR NAME <i>McCully Funeral Homes</i>					25a. DATE REC'D. BY REGISTRAR <i>Mar 29 1985</i>		25b. REGISTRAR'S SIGNATURE <i>John M. [Signature]</i>					

BP

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1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.



**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

08234

FOR  
1- STATE  
REGISTRAR

REG. NO.

021108

|   |                         |  |  |
|---|-------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Clara Mae White</b>   |                         | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR HOUR<br><b>3-21 19 85</b>  |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 24 23</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY MONTHS DAYS HOURS MIN<br><b>61 YRS.</b> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Mississippi</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |                         | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.   |  |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital - DOA</b>   |                         | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Board of Education</b>   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Custodian</b>   |                         | 13. STREET ADDRESS<br><b>1632 Warwick Avenue</b>   |  |
| 13a. CITY OR TOWN<br><b>Baltimore</b>   |                         | 13b. STATE<br><b>Maryland</b>  |  |
| 13c. COUNTY<br><b>Baltimore</b>   |                         | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Dennis</b>  |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Walker</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No.</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>220-01-3630</b>   |  |
| 17. INFORMANT<br><b>Renzy White</b>   |                         | 17. ADDRESS<br><b>1632 Warwick Avenue</b>  |  |
| 17. CITY OR TOWN<br><b>Baltimore</b>  |                         | 17. STATE<br><b>Maryland</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |                         |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____  |                         |  |  |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                         | 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                         | 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>  |                         | TITLE (SPECIFY)<br><b>Assistant</b> MEDICAL EXAMINER   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Dennis F. Smyth, M.D.</b>  |                         | DATE SIGNED<br><b>3-21-85</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>3/25/1985</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest Veterans</b>   |                         | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Funeral Home, Inc.</b>   |                         | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 27 1985</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>Wenderson-Randall</i>  |                         | 25c. ADDRESS<br><b>2501 Gyms Falls Parkway</b>   |  |
| 25d. CITY OR TOWN<br><b>Baltimore, Maryland</b>   |                         | 25e. STATE<br><b>21216</b>   |  |

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PW 3. RETAIN PAGE 5. YOUR FILES TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |   |  |   |  |  |  |
|---|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Helen R. White</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 16 1985</b> |   |  | 2b. HOUR<br><b>M</b>  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Cauc.</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 22 1899</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.<br>YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>John Hopkins Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>7 N. East Ave. 21224</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James McDonald</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Cora Lauver</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>218-03-7595</b>   |   | 17. INFORMANT ADDRESS<br><b>Alverta White 7 N. East Ave.</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ASCVD WITH SUSPECTED MYOCARDIAL INFARCTION</b>  |  |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |   |   |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |   |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |   |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>DAVID J. SEFF MD</b>   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  |   |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DAVID J. SEFF MD</b>  |  |   |   | 22e. ADDRESS<br><b>100 N. BROADWAY<br/>BALTO MD 212 31</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/19/85</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                              |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>B. Dabrowski &amp; Son 2818 E. Baltimore St.</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 18 1985</b>   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |

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02033



93814 ACTION 3007

ONDA VIA TELEFONO



MR. P. RAM

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

0870777

|  |  |   |  |  |   |  |
|--|--|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>LILLIAN WHITE  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3/21/85                                     |  | 2b. HOUR<br>5:30 AM   |  |
| 3. SEX<br>F  | 4. RACE<br>B   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>01 01 84  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>101<br>YRS                                      |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Baltimore MD   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                          |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>LUTHERAN HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING YEARS)<br>House Wife    |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE<br>(IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD  |  |   | 13b. COUNTY<br>C   | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>John W. White   |  |   | 15. MOTHER'S MAIDEN NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Cornelia Blank |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>C   |  | 17. INFORMANT<br>ADDRESS<br>Lillian Jones, (Grandmother)<br>4400 Lupton Ave, 21211 |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) SEPTIC SHOCK<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____   |  |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 10  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)     |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.                         |  |   |  |  |   |  |
| 22b. SIGNATURE<br>L. C. UETO   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>3/21/85  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>LEDUQUINA L. C. UETO  |  | 22e. ADDRESS<br>LUTHERAN HOSPITAL   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>3 26 85   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD                         |  |   |  |
| 24. FUNERAL DIRECTOR<br>McCurran Funeral Home 3207 St. North Ave   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 22 1985                                       |  |   |  |

087017



230 35 482



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|   |   |   |  |   |
|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>WILLIAM R. WHITLEY (WHITNEY) JR.   |   | 20. DATE KNOWN OF DEATH<br>X MONTH DAY YEAR<br>3 6 19 85  |  | 2b. HOUR<br>M<br>12:20  |
| 3. SEX<br>Male  | 4. RACE<br>Black  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 2 36   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>48 YRS.  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>3 6 19 85                             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                       |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2105 Barclay Street | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br>MD  | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 13e. STREET ADDRESS<br>2105 Barclay St. 21218                                       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William R. Whitley, Sr.   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Louvenia Wilson  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes  |   | 16b. SOCIAL SECURITY NO.<br>476   |  | 17. INFORMANT ADDRESS<br>Louvenia Taylor 416 E. Lafayette Av                        |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Stabwound of back</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  |   |   |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>12:10am 3/6/ 19 85   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject stabbed |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>home   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>2105 Barclay Street, Baltimore, MD          |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |   |   |  |   |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>  |   | TITLE (SPECIFY)<br>M.D. Assistant   |  | DATE SIGNED<br>3/6/85   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Dennis F. Smyth, M.D.   |   | ADDRESS<br>111 Penn Street, Balto, MD 21201   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>3/11/85  | 23c. NAME OF CEMETERY OR CREMATORY<br>GARRISON FOREST VA  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Owings Mills MD                                    |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H  |   | ADDRESS<br>1101 E. North Ave.   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 7 1985   |
| 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Rodale</i>  |   |   |  |   |

120.10



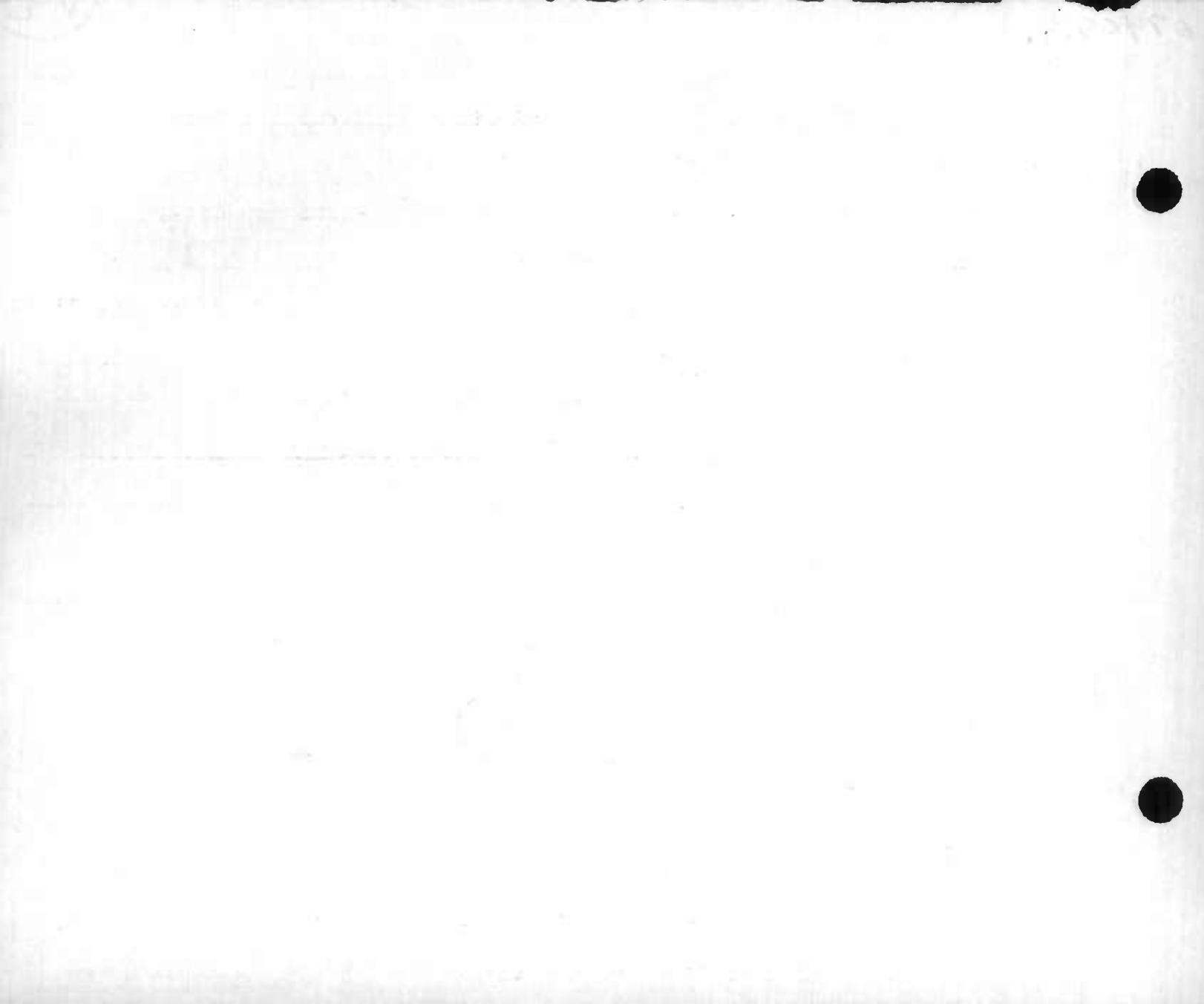
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>William Whittington   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 12, 1985  |  | 2b. HOUR<br>M  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 28 30  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>54 YRS.  |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S. Carolina   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1606 N. Bradford Street                 |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frank Whittington   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sarah Bowey   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>250-42-6972  |  | 17. INFORMANT<br>ADDRESS<br>A Alice Whittington 1606 N Bradford St                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic Lung Cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>                                      |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>79</u> , to <u>3/12</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3/11</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br><u>E. Lignos</u>  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>3-12-85  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Evangelos Lignos   |  | 22e. ADDRESS<br>201 E. University Pkwy, 21218  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL   |  | 23b. DATE<br>3/15/85   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cemetery                             |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H Inc. 1101 E North Avenue   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 13 1985   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall                                 |  |

BP \_\_\_\_\_



098085

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHAM - 17  
(VR A15 ME (5))  
20M 4/B2

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                     |  |  |  |   |  |   |                            | REG. NO. 08240  |  |
|--|--|---------------------|--|--|--|---|--|---|----------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ELLA Mae (Paul) WHYE</b>  |  |                     |  |  |  |   |  |   |                            | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>3 29 1985</b> |  |
| 3 SEX <b>Female</b>  |  | 4 RACE <b>Negro</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>04/25/11</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS. <b>73</b>                             |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN  |                            | 2c. DATE PRONOUNCED DEAD <b>3 29 1985</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  |                     |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |                     |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5002 The Alameda</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic Work</b>  |                            | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                     |  | 13a. STATE <b>Md.</b>  |  |   |  | 13b. COUNTY   |                            | 13c. CITY OR TOWN <b>City</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>James E. Carter</b>  |  |                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Ada Nickens</b>   |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                            |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>no</b>  |  |                     |  | 16b. SOCIAL SECURITY NO. <b>218-32-5840</b>  |  |   |  | 17. INFORMANT ADDRESS <b>Leonard Whye 5002 The Alameda</b>  |                            |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertensive &amp; arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                     |  |  |  |   |  |   |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                     |  |  |  |   |  |   |                            |   |  |
| 19a. DATE OF OPERATION   |  |                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |                            | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |                            |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |                            |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                     |  |  |  |   |  |   |                            |   |  |
| ACTUAL SIGNATURE <i>Ann M. Dixon</i>   |  |                     |  |  |  | TITLE (SPECIFY) <b>Assistant</b>  |  |   | DATE SIGNED <b>3-30-85</b> |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>  |  |                     |  |  |  | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>                                |  |   |                            |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |                     |  | 23b. DATE <b>4-4-85</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Maryland Nat'l Cen.</b>                 |  |   |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Laurel, Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS <b>Chatman-Harris 1701 McCulloh St.</b>   |  |                     |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>APR 2 1985</b>                               |  | 25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendall</i>  |                            |   |  |

MEDICAL CERTIFICATION

210-00



1985

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5

0 8 2 4 1

REG. NO.

|   |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>VIRGINIA A. WIDENER</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 4, 1985</b>            |   | 2b. HOUR<br><b>5:45AM</b>  |  |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 20 1944</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>40</b> YRS.<br>IF UNDER 1 YEAR: MONTHS DAYS<br>IF UNDER 24 HRS: HOURS MIN. |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Kentucky</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Education</b>  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Virginia</b>   |  |  | 13b. COUNTY<br><b>Washington</b>                                       |   | 13c. CITY OR TOWN<br><b>Bristol</b>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Luster Palmer</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Gladys Branson</b> |   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>319 Meadowcrest Drive 24201</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>406-58-6711</b>   |  | 17. INFORMANT<br><b>Hunter P. Widener</b>   |  |  |  | ADDRESS<br><b>319 Meadowcrest Drive<br/>Bristol, Virginia</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hepatic Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Veno Occlusive Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Bone Marrow Transplant</b>  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>5 days</b><br><b>4 1/2 weeks.</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Acute myelogenous Leukemia</b>   |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>1/14</b> , 19 <b>85</b> , to <b>3/4</b> , 19 <b>85</b> , that (1) (we) lost<br>saw the deceased alive on <b>5:45AM 3/4</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (1) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Eric Larsen MD</b>   |  |  |  | DEGREE<br><b>MD</b>   |  |  | 22c. DATE SIGNED<br><b>3/4/85</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Eric Larsen</b>   |  |  |  | 22e. ADDRESS<br><b>Dept Peds, Johns Hopkins Hosp.</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3-8-85</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount View Cemetery</b>  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Bristol, Washington, Virginia</b>   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Marzullo Funeral Service</b>   |  |  |  | ADDRESS<br><b>Reisterstown, Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 5 1985</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Eric Davidson-Randall</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

098047

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM F. WILDBERGER</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-25-85</b>                            |  | 2b. HOUR<br>M                                      |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 23, 1910</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b>                               | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>600 Light Street 21230</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sales</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Baking</b> |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b> |  |   | 13b. COUNTY<br><b>--</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>                                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>August Martin Wildberger</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Jane Wirsing</b>        |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>---</b><br><b>216-01-7285</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. W.F.Wildberger 600 Light St. 21230</b> |  |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the Lung</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>1 1/2 yrs.</b> |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

|  |  |  |  |   |   |
|--|--|--|--|---|---|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-21</b> , 19 <b>85</b> , to <b>3-25</b> , 19 <b>85</b> , that (I) (we) last<br>saw the deceased alive on <b>3-21</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |
| 22b. SIGNATURE<br><b>Alan Adelman</b>  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>3-28-85</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Alan Adelman</b>   |  | 22e. ADDRESS<br><b>600 Light St Baltimore, MD 21201</b>                |  |   |   |

|   |                             |   |   |
|---|-----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                               | 23b. DATE<br><b>3-29-85</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Mausoleum</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Parkville Balto. Md.</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home 6500 York Road 21212</b> |                             | 25. DATE REC'D. BY REGISTRAR<br><b>APR 2 - 1985</b>             |   |
|   |                             | 25b. REGISTRAR'S SIGNATURE<br><b>Gabe Davidson</b>              |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as not shown any injury, or other traumatic event, the medical examiner must be notified at once.



BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |  | REG. NO.   |   |   |   |  |
|---|--|---|---|--|--|---|---|---|--|
| 1. FOR STATE REGISTRAR  |  |   |   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |   |   |   |  |
| I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Mary Elizabeth Wilhelm</b>   |  |   |   |  | 3/17/1985 3:13 P.M.  |   |   |   |  |
| 3. SEX<br>female  |  | 4. RACE<br>white  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>May 17, 1908  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS   |   | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                        |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Jenkins Memorial Home<br>1000 S. Caton Ave. Balt. Md. 21229 |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>housewife        |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>own home   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore  |  |   |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET ADDRESS<br>1000 S. Caton Avenue 21229                     |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Ernest S. Geelhaar   |  |   |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary E. Sutton   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>no   |  |   |   |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS<br>Mr. Lawrence Wilhelm 322½ Townsend Rd. 21221 |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line of (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>HASCVD</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |   |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 WKS<br>15 YRS   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____   |  |   |   |  |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)    |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |   |   |  |
| 22a. I certify that (this hospital) attended the deceased from <u>2-28</u> , 19 <u>72</u> , to <u>3-17</u> , 19 <u>85</u> , that (he/we) lost saw the deceased alive on <u>3-17</u> , 19 <u>85</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did/did not) view the body after death.           |  |   |   |  |  |   |   |   |  |
| 22b. SIGNATURE<br><u>John F. Hartman, M.D.</u>  |  |   |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>3-17-85   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JOHN F. HARTMAN, M.D.  |  |   |   |  | 22e. ADDRESS<br>BALTO. MD<br>JENKINS 1000 S. CATON AVE. 21229  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   | 23b. DATE<br>3/20/85  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cemetery   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore City Maryland    |   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br>Ambrose Funeral Home 1328 Sulphur Spring Road  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 18 1985   |   | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall                   |   |  |

WILHELM

WILHELM

1000 S. O'CONNOR AVE. BOSTON, MASS.  
JENNINGS MEMORIAL HOME

HASCO

of the Corporation and  
part of the

082036

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR  |  | 2b. HOUR   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST   |  | MARCH 9, '85  |  | 12:25AM  |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE   |  |
| FEMALE  |  | WHITE   |  | MONTH DAY YEAR<br>01-26-10  |  | 75 YRS.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| WEST VIRGINIA   |  | U.S.A.  |  | BALTIMORE CITY  |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| BALTO.  |  | FRANCIS SCOTT KEY HOSP.   |  | FEEDER  |  | TACK CO.   |  |
| 13a. USUAL RESIDENCE<br>(IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. STATE  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?                                       |  |
| MD.   |  | BALTO.  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  | 13e. STREET ADDRESS   |  | 13f. STREET ADDRESS  |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST   |  | 21221   |  | 21221  |  |
| ASA STALNAKER   |  | BESSIE M. DARNELL   |  | Mr. John N. Cincioni - 1021 ARNCLIFFE RD.   |  | 21221  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS  |  |
| No.   |  | 235-20-5419   |  | Mr. John N. Cincioni - 1021 ARNCLIFFE RD.   |  | 21221  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) EXACERBATION OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) CONGESTIVE HEART FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) LEUKEMIA (Chronic Myelocytic)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 DAYS<br>3 DAYS<br>1 YEAR |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br>PEPTIC ULCER DISEASE  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (he) (this hospital) attended the deceased from 3/8, 19 85, to 3/8, 19 85, that (I) (we) last saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.  |  | 22c. DATE SIGNED  |  |   |  |  |  |
| 22b. SIGNATURE<br>Christina M. Link T. Parran MD  |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 3/9/85   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CHRISTINA M. LINK PARRAN   |  | 22e. ADDRESS<br>BCH Dept Mar  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |  |
| BURIAL  |  | 3-12-85   |  | GLEN HAVEN CEM.   |  | BALTO. MD.   |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  | 24b. ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                                     |  |
| Hartley Miller - 2334 Jefferson St.   |  |   |  | MAR 12 1985   |  | Gina Davidson-Randall  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2001.5.15AM



082037

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8245

|   |  |   |  |   |   |
|---|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MARY MIDDLE K. LAST WILL   |  |   | 20. DATE OF DEATH<br>MONTH DAY YEAR<br>MARCH 03, 1985                          |   | 21. HOUR<br>(9:45 P.M.)   |
| 3. SEX<br>Female  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 5 1904  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Miss.  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Supervisor |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Packing Hse.               |
| 13a. STATE<br>Md.   |  | 13b. COUNTY   | 13c. CITY OR TOWN<br>Balto.  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Trawinski  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Josephine Sala   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>212-09-1906   |  | 17. INFORMANT<br>ADDRESS<br>Rita Yanczewski 327 S. Chapel Street                                |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) ACUTE PULMONARY EDEMA<br>DUE TO, OR AS A CONSEQUENCE OF PULMONARY EMBOLISM<br>(c) ACUTE MYOCARDIAL INFARCTION AND /OR |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.  |  |   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (1) (this hospital) attended the deceased from MARCH 03, 1985, to MARCH 03, 1985, that (1) I saw the deceased alive on MARCH 03, 1985, and that in (my) opinion death occurred on the date and hour and I am the causes stated above, (b) we did not view the body after death.   |  |   |  |   |   |
| 22b. SIGNATURE<br>CORAZON VERGARA-SOARES  |  | DEGREE<br>M.D.  |  | 22c. DATE SIGNED<br>3-4-85  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CORAZON VERGARA-SOARES   |  | 22e. ADDRESS<br>CHURCH HOSPITAL CORPORATION<br>100 NORTH BROADWAY BALTO., MD. 21231   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>3-7-1985   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Sacred Hrt. Jesus   |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.  |  | 23e. DATE REC'D. BY REGISTRAR<br>MAR 8 1985   |  | 23f. REGISTRAR'S SIGNATURE  |   |
| 24. FUNERAL DIRECTOR<br>John M. Weber & Sons Inc. 401 S. Chester St   |  |   |  |   |   |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   | 8 5 0 8 2 4 6  |   |  |  |  |   |  |
|--|--|--|--|---|--|---|--|--|--|---|--|
| 0820381 - FOR STATE REGISTRAR  |  |  |  |   | REG. NO.   |   |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Alberta D. Williams  |  |  |  |   | 7a. DATE OF DEATH MONTH DAY YEAR<br>March 7, 1985  |   |  |  |  | 7b. HOUR<br>9:55A M                             |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 8 30  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>54<br>YRS.   |  | 8. IF UNDER 1 YEAR<br>MONTHS DAYS                              |  | 8. IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |   |  |  |  |   |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>2308 Round Rd. 21225         |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Rev. James T. Rose   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>MIDDLE LAST<br>Callie Jones  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) NO  |  |  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>223-36-3946   |   | 17. INFORMANT ADDRESS<br>Jacob Williams 2308 Round Rd.                               |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Respiratory arrest  |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <div style="display: flex; justify-content: space-between;"> <div style="width: 40%;">             (b) Renal cell carcinoma with metastases to brain           </div> <div style="width: 40%;">             (c)           </div> </div> |  |  |  |   |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from January 14, 19 85, to March 7, 19 85, that (we) lost saw the deceased alive on March 7, 19 85, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) not view the body after death.                                |  |  |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>Rebecca Byrd M.D.  |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  |  |  | 22c. DATE SIGNED                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Rebecca Byrd, M.D.  |  |  |  |   | 22e. ADDRESS<br>c/o Maryland General Hospital  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  | 23b. DATE<br>3/13/85   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Memorial   |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. MD |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 8 1985  |   | 25b. REGISTRAR'S SIGNATURE<br>J. Davidson-Randall                                    |  |  |   |  |

BP 13

1

VOIDED DEATH CERTIFICATE NUMBER 85-08247

April 85 death



098093

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>DONALD WILLIAMS SR</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 30, 85</b>                             |   | 2b. HOUR<br>M  |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>BALCK</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MARCH 7, 1915</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.                                      | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MT. AIRY, MD.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> MD.                           |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PROVIDENT HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>BALTO. CITY</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>EDUCATION</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>BALTO.</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>3214 WESTWOOD AVE.</b>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES WILLIAMS</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARTHA</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>705-05-8443</b>  |  | 17. INFORMANT ADDRESS<br><b>FLORA WILLIAMS 3214 WESTWOOD AVE.</b>                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>HEART ATTACK</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>EXACERBATION COPD</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)    |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>5/7</b> , 19 <b>84</b> , to <b>MARCH</b> 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>MARCH</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |
| 22b. SIGNATURE<br><i>[Signature]</i>   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>4/1/85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SCHAEFER, SDW. W.</b>  |  | 22e. ADDRESS<br><b>730 ARBURN ST. 21216</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  | 23b. DATE<br><b>4/5/85</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARBUTUS MEMORIAL PK. BALTO., MD.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>LEROY O. DYETT 4600 LIBERTY HGTS. AVE.</b>  |  | 25. DATE REC'D. BY REGISTRAR<br><b>APR 2-1985</b>   |  |   |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP



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17-3-14



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 2 4 9

088055

1- FOR  
STATE  
REGISTRAR

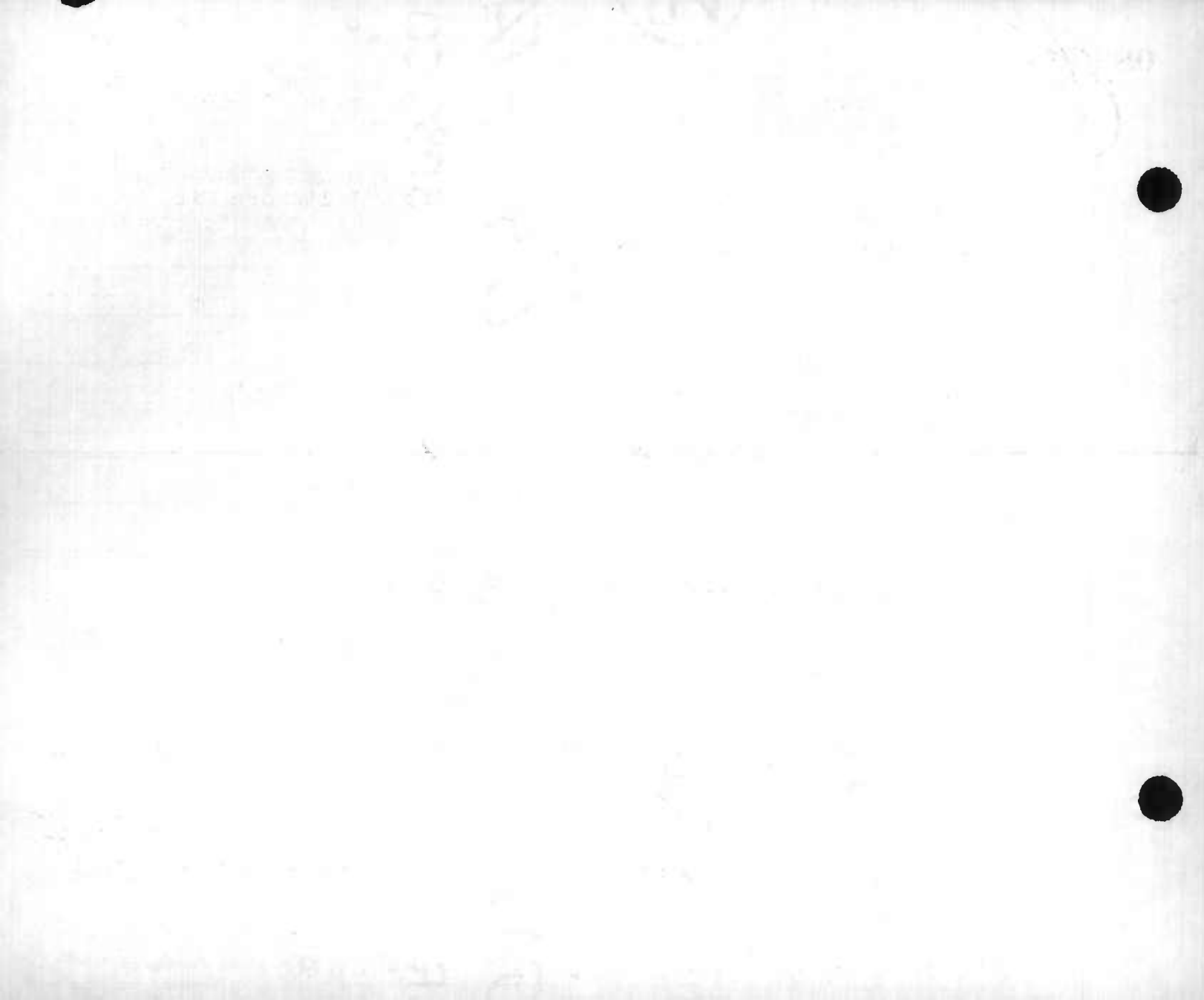
REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Edna Williams  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>March 25, 1985  |  | 2b. HOUR<br>M  |
| 3. SEX<br>Female  | 4. RACE<br>Black  | 5. DATE OF BIRTH MONTH DAY YEAR<br>5 14 06  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS.   | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS)<br>1600 Mt. Royal Ave. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MD 13b. COUNTY 13c. CITY OR TOWN Baltimore  |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>1600 N. Bolton St 21217  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>216-22-4260   |   | 17. INFORMANT ADDRESS<br>Sandra Little 516 Tumbridge Rd.                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Acute m. I. ?<br>DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF (c) |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br>Lt. L. Bat. Thrown by plane   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-10-1983 to 3-25-1985, that (I) (we) lost<br>saw the deceased alive on 3-9-85, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                     |   |   |   |  |  |
| 22b. SIGNATURE<br>A. Poller   |   | DEGREE<br>M.D.  |   | 22c. DATE SIGNED<br>3-25-85  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ASADIA SIDER   |   | 22e. ADDRESS<br>1009 109th St. Baltimore MD 21221   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |   | 23b. DATE<br>3/30/85  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>King Mem. Pk.                                  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co MD   |   | 23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE<br>MAR 26 1985 John Davidson-Randall   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Wm. C. March F/H 1101 E. North Ave.   |   |   |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



09308

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE  
REGISTRAR

|  |  |  |  |   |  |   |  |                            |  |                  |  |                                      |  |       |  |          |  |      |  |          |  |
|--|--|--|--|---|--|---|--|----------------------------|--|------------------|--|--------------------------------------|--|-------|--|----------|--|------|--|----------|--|
| 1. DECEASED NAME<br>(PLEASE PRINT)   |  | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN OF DEATH    |  | MONTH            |  | DAY                                  |  | YEAR  |  | 2b. HOUR |  |      |  |          |  |
| FRANKLIN E. WILLIAMS Sr  |  |  |  |   |  |   |  | 3 29 19 85                 |  |                  |  |                                      |  |       |  | 4:30 PM  |  |      |  |          |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.             |  | IF UNDER 24 HRS. |  | 7c. DATE PRONOUNCED DEAD             |  | MONTH |  | DAY      |  | YEAR |  | 2d. HOUR |  |
| male   |  | black  |  | 12 30 36  |  | 48 YRS.   |  |                            |  |                  |  | 3 29 19 85                           |  |       |  |          |  |      |  | 4:30 PM  |  |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |  | XX NEVER MARRIED  |  | WIDOWED                    |  | DIVORCED         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |       |  |          |  |      |  | MD.      |  |
| Maryland   |  | U.S.A.   |  |   |  |   |  |                            |  |                  |  | Baltimore City                       |  |       |  |          |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                            |  |                  |  |                                      |  |       |  |          |  |      |  |          |  |
| Baltimore  |  | 1102 E. Pratt St.  |  |   |  |   |  |                            |  |                  |  |                                      |  |       |  |          |  |      |  |          |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS        |  |                  |  |                                      |  |       |  |          |  |      |  |          |  |
| Maryland   |  |  |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1102 E. Pratt St. 21202    |  |                  |  |                                      |  |       |  |          |  |      |  |          |  |
| 14. FATHER'S NAME  |  | MIDDLE   |  | LAST  |  | 15. MOTHER'S MAIDEN NAME  |  | MIDDLE                     |  | LAST             |  |                                      |  |       |  |          |  |      |  |          |  |
| John   |  | H.   |  | Williams  |  | Rose  |  |                            |  | Andrews          |  |                                      |  |       |  |          |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |                            |  |                  |  |                                      |  |       |  |          |  |      |  |          |  |
| NO   |  | 213-32-4037  |  | Verna William   |  | 1102 E Pratt Street   |  |                            |  |                  |  |                                      |  |       |  |          |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of the neck</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |   |  |                            |  |                  |  |                                      |  |       |  |          |  |      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |   |  |   |  |                            |  |                  |  |                                      |  |       |  |          |  |      |  |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                            |  |                  |  |                                      |  |       |  |          |  |      |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |                            |  |                  |  |                                      |  |       |  |          |  |      |  |          |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |  |                            |  |                  |  |                                      |  |       |  |          |  |      |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  | TITLE (SPECIFY)  |  | DATE SIGNED   |  | 3-30-85   |  |                            |  |                  |  |                                      |  |       |  |          |  |      |  |          |  |
| ACTUAL SIGNATURE   |  | M.D. Assistant   |  | MEDICAL EXAMINER  |  |   |  |                            |  |                  |  |                                      |  |       |  |          |  |      |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  | Ann M. Dixon, M.D.   |  | ADDRESS   |  | 111 Penn St., Balto., Md. 21201                                     |  |                            |  |                  |  |                                      |  |       |  |          |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |                            |  |                  |  |                                      |  |       |  |          |  |      |  |          |  |
| BURIAL   |  | 4/5/85   |  | Mount Auburn Cem.   |  | Baltimore, Md.  |  |                            |  |                  |  |                                      |  |       |  |          |  |      |  |          |  |
| 24. FUNERAL DIRECTOR   |  | NAME   |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE |  |                  |  |                                      |  |       |  |          |  |      |  |          |  |
| Wm. C March F/H Inc.   |  | 1101 E North Avenue  |  | APR 1 - 1985  |  | Julia Davidson-Randall  |  |                            |  |                  |  |                                      |  |       |  |          |  |      |  |          |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 4 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

087084

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  | REG. NO.                                     |  |
|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR             |  |
| 1 DECEASED NAME FIRST MIDDLE LAST<br><b>HERMAN WILLIAMS</b>  |  |   |  |  | 2b. HOUR<br><b>9:35am</b>                    |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>MAY 7, 1912</b>  |  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.  |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  | 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE CITY</b>   |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b>  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>VICE PRES.</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MASH'S HAMS</b>                                      |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTO.</b>  |  | 13c. CITY OR TOWN<br><b>OWINGS MILLS</b>   |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>MAX WILLIAMS</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>ANNA UNKNOWN</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-09-9537</b>  |  | 17. INFORMANT<br><b>ALAN J. WILLIAMS APT. 302</b><br><b>9520 PERRY HALL BLVD. #21236</b>     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Renal Failure</b> |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Renal Failure, Congestive Heart Failure</b>   |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)          |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                               |  |  |
| 21c. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21e. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-14</b> 19 <b>85</b> , to <b>3-20</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>3-20</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Raefat Y. Girges</b>  |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3/20/85</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RAEFAT Y. GIRGES, M.D.</b>   |  | 22e. ADDRESS<br><b>ST. AGNES HOSP. - BALTO., MD</b>   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>MAR. 21, 1984</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BNAI JACOB</b>                                      |  |  |
| 23d. LOCATION<br><b>BALTIMORE</b>  |  | COUNTY <b>MARYLAND</b>  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>   |  | ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 22 1985</b>  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>L. Davidson</b>   |  |   |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/cremation permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as learned, no warning injury, or other traumatic event, the medical examiner must be notified of death.

098056

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 - 0 8 2 5 2

REG. NO.

|  |  |  |   |   |  |  |  |
|--|--|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>HORACE WILLIAMS</i> |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>3-29-85</i> |   |  | 2b. HOUR<br>M<br><i></i>   |  |
| 3. SEX<br><i>male</i>  |  | 4. RACE<br><i>Col.</i>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>5-12-28</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><i>64</i>   |  |
| 7a. BIRTHPLACE<br>(COUNTRY)<br><i>North Carolina</i>                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>749 Grantley St.</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Retired</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i></i>   |  |
| 13a. STATE<br><i>Maryland</i>  |  | 13b. COUNTY<br><i>Baltimore</i>  |   | 13c. CITY OR TOWN<br><i>Baltimore</i>   |  | 13d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO              |  |
| 13e. STREET ADDRESS / ZIP CODE<br><i>749 Grantley St 21229</i>                     |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>EUNA WILLIAMS</i>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Rebecca Cuerby</i>  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>NO</i> |  |
| 16b. SOCIAL SECURITY NO.<br><i>226-12-4635</i>                                     |  | 17. INFORMANT<br><i>Mrs. Rebecca Williams</i>  |   | ADDRESS<br><i>749 Grantley St 21229</i>   |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) *CARDIO-PULMONARY ARREST*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.(b) *athero-sclerotic Cardio-vascular disease* Y12S

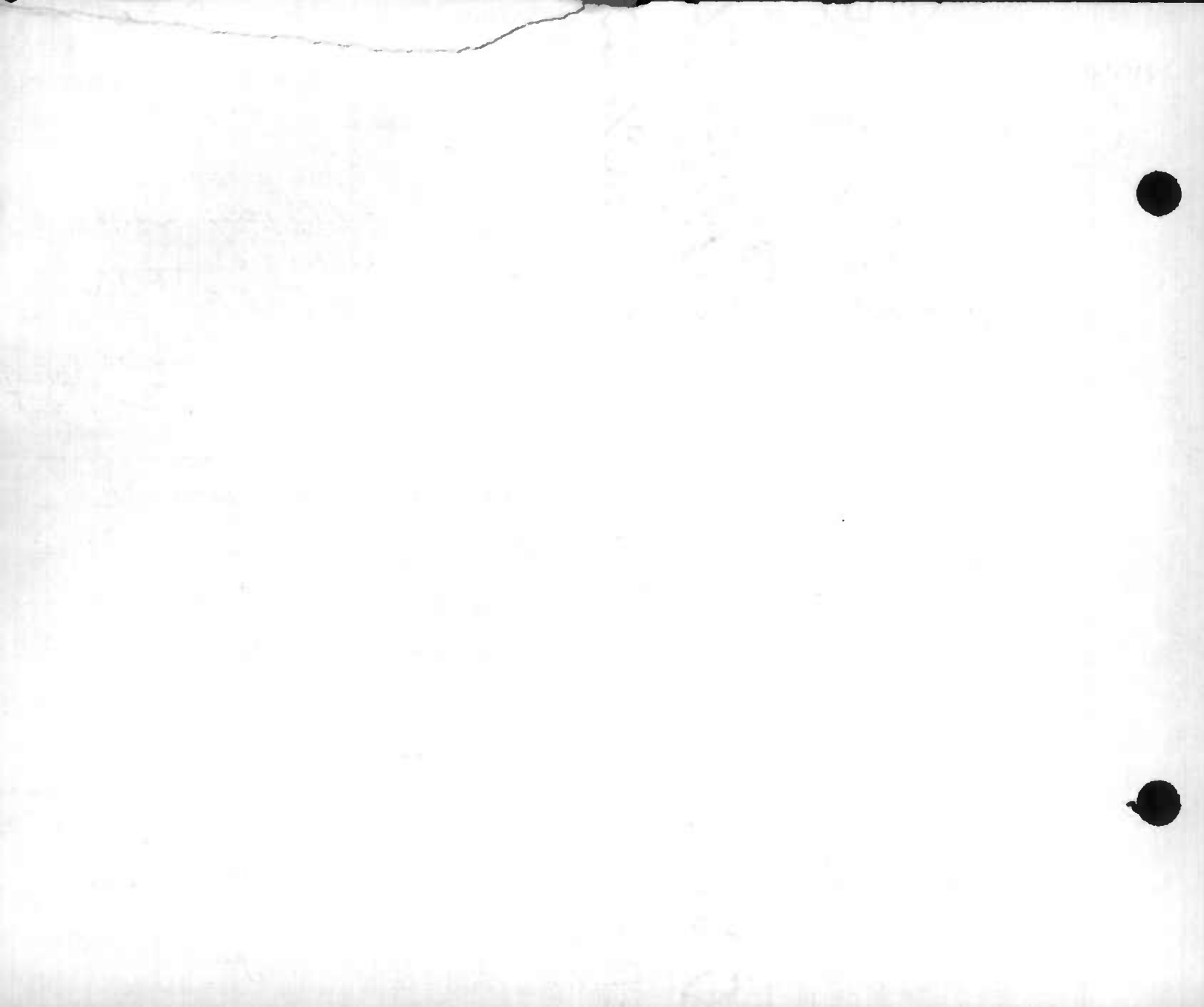
DUE TO, OR AS A CONSEQUENCE OF

(c) *HYPERTENSION* Y12SAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

*DIABETES mellitus*

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                          |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8/</i> 19 <i>82</i> , to <i>3/</i> 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>3/15</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Richard M. Hodes</i>  |  | DEGREE<br><i>MD</i>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/><br>DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>3/30/85</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>RICHARD M HODES</i>  |  | 22e. ADDRESS<br><i>FRANCIS Scott Key HOSPITAL<br/>BALTIMORE, MD 21224</i> |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK)<br><i>BURIAL</i>  |  | 23b. DATE<br><i>4-5-85</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Arbutus Memorial</i>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>BALTIMORE Co. Md.</i>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Joseph L. Russ</i>  |  | ADDRESS<br><i>2222 W. North Ave.</i>                                      |  | 25a. DATE REC'D. BY REGISTRAR<br><i>APR 2 - 1985</i>   |  |   |  |



079037

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |  |  |   |   |  |
|--|--|---|---|---|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>James Williams</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 12 85</b>                   |   |  | 2b. HOUR<br><b>9 PM</b>  |   |   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>Black</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 24 1927</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b> YRS                                     |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto, MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.                       |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church &amp; Home Hosp.</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>None</b>      |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Balto</b>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1326 E Fayette Street 21231</b>                 |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harry Williams</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Dorothy America</b> |   |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>219-22-8170</b>                          |   | 17. INFORMANT<br>ADDRESS<br><b>Alena Williams 2624 Hatford Rd.</b>   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b>  |  |   |   |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>0</b>   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>LUNG CANCER</b>   |  |   |   |   |  |  |   | <b>1 month</b>  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |   |   |  |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>ATRIAL FIBRILLATION</b>  |  |   |   |   |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                        |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>       |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>2</b> , 19 <b>85</b> , to <b>3</b> , 19 <b>85</b> , that (1) (we) lost<br>saw the deceased alive on <b>3/11</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (1) (we) (did) (did not) view the body after death. |  |   |   |   |  |  |   |   |  |
| 22b. SIGNATURE<br><b>C. W. Hendrix</b>   |  |   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   | 22c. DATE SIGNED<br><b>3/14/85</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. W. HENDRIX</b>  |  |   |   |   | 22e. ADDRESS<br><b>600 N. Wolfe St, Baltimore, MD</b>  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  |   | 23b. DATE<br><b>3-19-85</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto MD</b> |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Jeff Miller F.S. 4611 Park Hgts</b>   |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 15 1985</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>R. Davidson-Randall</b>      |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

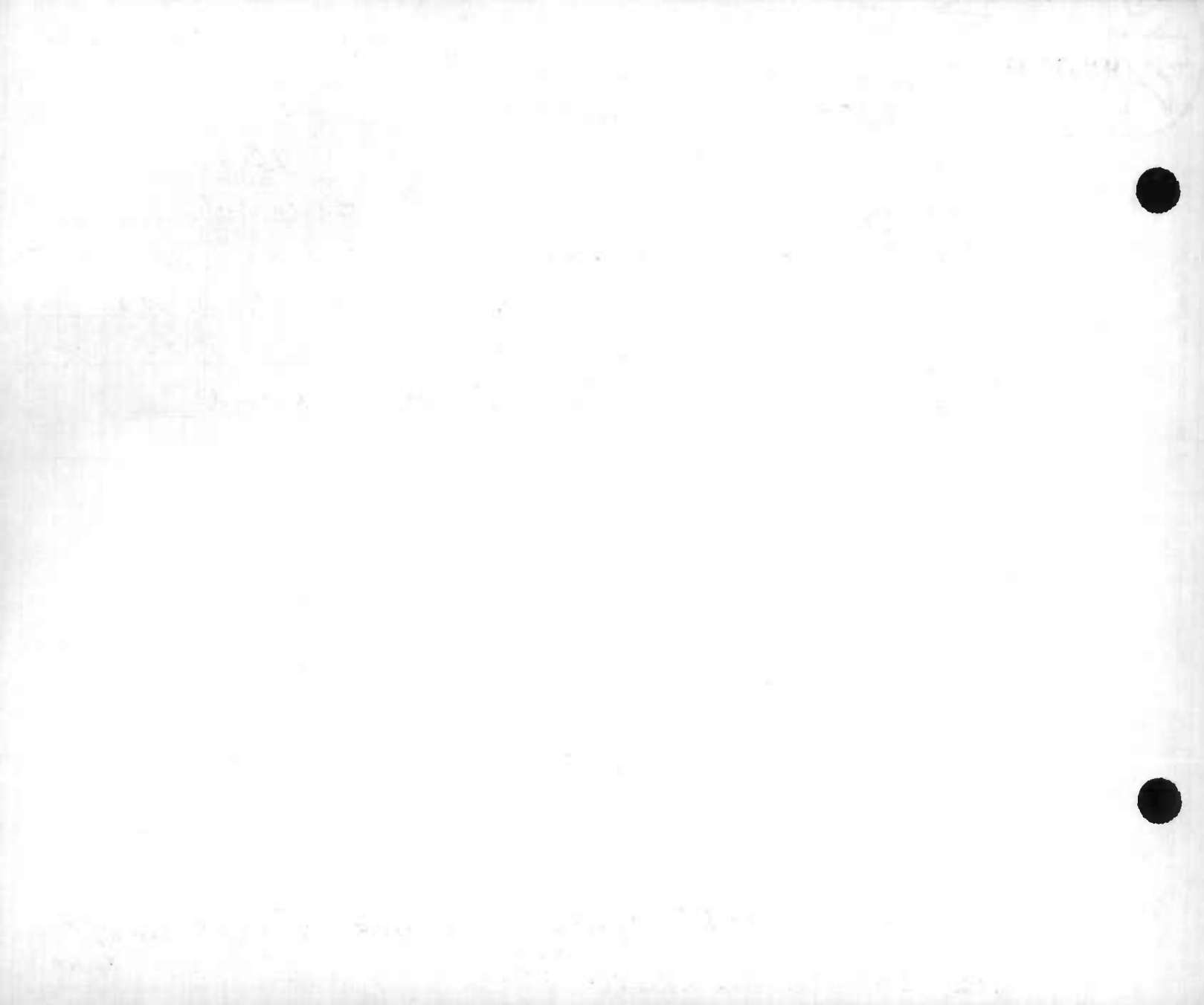
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FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |   |  |  |  |  |  |  |  |
|---|--|--|---|---|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOUSH WILLIAMS</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-19-85</b>                               |   | 2b. HOUR<br><b>10:10 AM</b>   |  |  |  |  |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>BLACK</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 2 12</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.  |  | 7. UNDER 1 YEAR<br>MONTHS DAYS<br><b>72</b>  |  | 8. UNDER 24 HRS.<br>HOURS MIN.<br><b>10:10</b> |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>North Carolina</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.   |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Key Circle Hospice</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mechanic</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Restaurant</b> |  |  |  |
| 13a. STATE<br><b>D.C.</b>   |  | 13b. COUNTY<br><b>✓</b>  |   | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3545 13th St. N.W. 99999</b>  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WESTLEY WILLIAMS</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>NELLIE SWADER</b>   |   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  |   | 16b. SOCIAL SECURITY NO.<br><b>131-05-4072</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Pt's Medical Record</b>   |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>PNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>ADENO CARCINOMA</b> (b) <b>PROSTATE</b> |  |  |   |   |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>NA</b>                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>NA</b>                        |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>NA</b> |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>NA</b> |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>NA</b>                              |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-11-85</b> to <b>3-19-85</b> , that (I) (we) lost<br>saw the deceased alive on <b>3-18-85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Surjit S</b>   |  |  | DEGREE  |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>3/19/85</b>                     |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SURJIT S JULKA</b>  |  |  |   |   | 22e. ADDRESS<br><b>KEY CIRCLE HOSPICE</b>   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>03-28-85</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Maryland Natl. Cemetery</b>                        |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>College Pk. Maryland</b>  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>W.H. Bacon Funeral Home</b>  |  |  | ADDRESS<br><b>3447 14th St N.W. WASH. DC</b>  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 21 1985</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>       |  |  |  |



078145

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

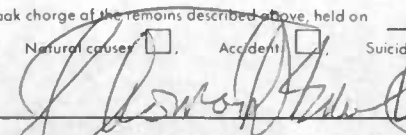
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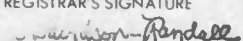
1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |                         |   |  |   |                                |   |  |
|--|-------------------------|---|--|---|--------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Julius E. Williams</b>                   |                         |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>3/ 16/ 19 85</b> |   |                                | 2b. HOUR<br>M<br><b>6:17 A M</b>  |  |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 18 66</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>18 YRS.</b>  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.<br>HOURS MIN. | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>3/ 16/ 19 85</b>                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                       |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                      |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital</b> |  |   |                                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Julius Williams</b>                   |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Romain L. Tillett</b>   |  | 13e. STREET ADDRESS<br><b>2563 McCulloh St. 21217</b>   |                                |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b> |                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>N/A</b>   |  | 17. INFORMANT ADDRESS<br><b>Romain Tillett 2563 McCulloh St.</b>  |                                |   |  |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Gunshot Wound to Chest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
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| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.  |  |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>5:15 PM 3/16/19 85</b> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>subject shot during robbery,</b> |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>street</b> | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>McCulloh &amp; Winchester Sts., Balto. City, Md.</b>         |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |
| ACTUAL SIGNATURE  M.D. Dep. Chief MEDICAL EXAMINER  |  | DATE SIGNED <b>3/16/85</b>   |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>   |  | ADDRESS <b>111 Penn St.</b>  |

|  |                             |  |   |
|--|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>                                     | 23b. DATE<br><b>3/21/85</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Auburn Cem.</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm C March F/H Inc. 1101 E North Ave.</b> |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 18 1985</b>            | 25b. REGISTRAR'S SIGNATURE<br> |

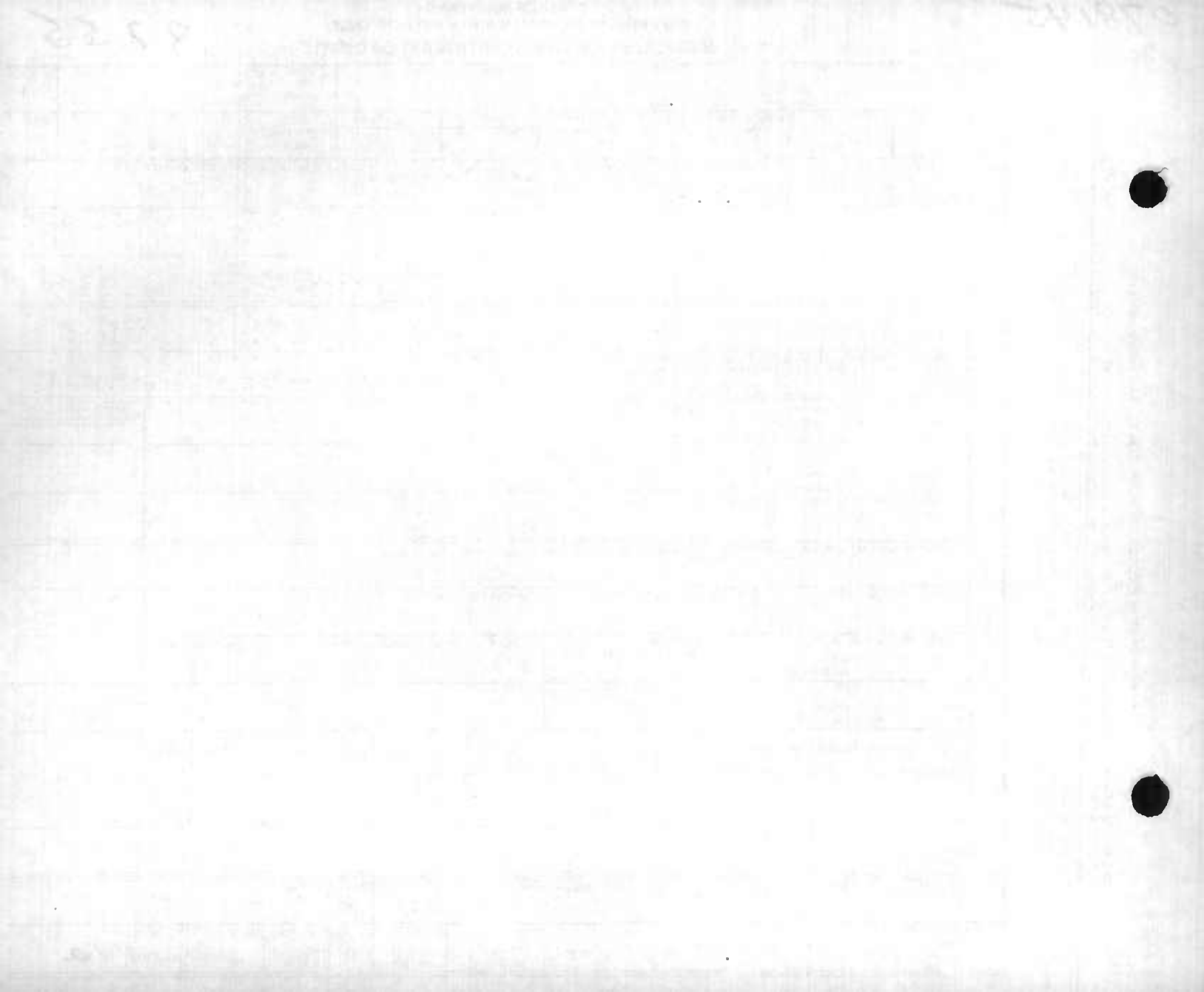
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | REG. NO.   |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MERL FOSTER WILLIAMS</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>MARCH 2, 1985</b>                             |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>2 12 05</b>                                    |  |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b>   |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                        |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Maintenance</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Mobil Oil</b>   |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. CITY OR TOWN<br><b>Hanover</b>   |  | 13c. STREET ADDRESS / ZIP CODE<br><b>7407 Ridge Road 21076</b>                       |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Thomas Williams</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Bertha Unknown</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>160-07-2567</b>  |  | 17. INFORMANT ADDRESS<br><b>Norma Fink 415 W. Maple Road 21090</b>                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Constrictive Heart Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Severe Obstructive Pulmonary disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Cor pulmonale</u><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CONTRIBUTING TO DEATH</u>   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-9-85</u> , 19 <u>85</u> , to <u>3-2-85</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3-2-85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Philip Mhan</u>  |  | DEGREE<br><u>MD</u>   |  | 22c. DATE SIGNED<br><u>3-2-85</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Philip Mhan</b>   |  | 22e. ADDRESS<br><b>St. Agnes Hospital</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3/6/85</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fairlawn Cemetery</b>                       |  |
| 23d. LOCATION CITY OR TOWN<br><b>Dalton</b>   |  | COUNTY<br><b>Pennsylvania</b>   |  | STATE  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Hubbard Funeral Home, Inc.</b>  |  | ADDRESS<br><b>4107 Wilkens Ave.</b>   |  | 25. DATE REC'D. BY REGISTRAR<br><b>MAR 4 1985</b>                                    |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>W. Davidson-Randall</u>  |  |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |   |   |  |  |   |  | REG. NO. 8 5 0 8 2 5 7  |  |
|---|--|--|---|---|---|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |   |   |   |  |  |   |  |   |  |
| 1. DECEASED NAME<br>(Type or Print)<br>FIRST MIDDLE LAST<br><b>Pauline C. Williams</b>  |  |  |   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3/22/1985</b>  |  |   | 2b. HOUR<br>M<br><b>M</b>  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 12 1908</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>77</b>   |  | IF UNDER 72 HRS<br>HOURS MIN.<br><b>77</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Texas</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>206 Suter Road</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Domestic</b>  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Pvt. Families</b>  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |  |   | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>206 Suter Road Catonsville, Maryland 21228</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Porter Lattimer</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Molly J. Bly</b>  |   |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No.</b>  |  |  |   | 16b. SOCIAL SECURITY NO.<br><b>451-26-2482</b>  |   | 17. INFORMANT<br><b>Annie R. Goodman</b> ADDRESS<br><b>206 Suter Road Baltimore, Maryland 21228</b>  |  |   |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b>  |  |  |   |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 minutes</b>                   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Dehydration</b>  |  |  |   |   |   |  |  |   |  | <b>3 days</b>   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Metastatic malignant adenocarcinoma of stomach</b>   |  |  |   |   |   |  |  |   |  | <b>3 months</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a   |  |  |   |   |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>1/28/85</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Carcinoma of stomach</b> |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>               |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)          |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/20</b> , 19 <b>85</b> , to <b>3/22</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>3/8</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. |  |  |   |   |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Sandy Fogel</b>  |  |  | DEGREE<br><b>MD</b>   |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED<br><b>3/22/85</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Sandy Fogel</b>   |  |  | 22e. ADDRESS<br><b>220 W Cold Spring La. Balt. Md.</b>                          |   |   |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>3/28/1985</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Maryland National Mem.</b> |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Laurel, Maryland</b>                           |  |   |  |
| 24. FUNERAL HOME<br>NAME ADDRESS<br><b>Nutter &amp; Sons 2501 Gwynns Falls Parkway</b>  |  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 27 1985</b>  |  |   |  |   |  |
| 24b. FUNERAL HOME, INC. BALTIMORE, MARYLAND 21216   |  |  |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |   |  |

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |  |  |  |  |   |  |
|---|--|---|---|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Queenie Lila Williams   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 11, 1985 |  | 2b. HOUR<br>11:28 AM   |  |  |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>BLACK  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>09-13-08   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.<br>IF UNDER 1 YEAR (MONTHS) DAYS<br>IF UNDER 24 HRS. (HOURS) MIN. |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>The Johns Hopkins Hospital |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>BALTIMORE  |   | 13c. CITY OR TOWN<br>CITY  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>              |  | 13e. STREET ADDRESS / ZIP CODE<br>3403 MAYFAIR ROAD 21207 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Williams   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ANGIE NORA Robert  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-24-0670                                       |  | 16c. ADDRESS<br>IRENE BROOKS 3403 MAYFAIR RD              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bowel Infection</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Atherosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>48h  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |   |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/9/85</u> , 19____, to <u>3/11/85</u> , 19____, that (I) (we) lost<br>saw the deceased alive on <u>3/11/85</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>about (I) (we) (did) (did not) view the body after death.              |  |   |   |  |  |  |  |   |  |
| 22b. SIGNATURE<br><u>Jonathan Israel</u>  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br>3/11/85                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jonathan Israel  |  |   |   | 22e. ADDRESS<br>601 N. Wolfe St Baltimore MD 21205   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>3-16-85  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Mem. Pl.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MD.  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>BROWN/Thompson F.H.   |  |   |   | ADDRESS<br>1913 W. BALTO. ST.  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 13 1985   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Davidson</u>             |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201





078139

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85

08259

FOR  
1- STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |  |   |  |  |
|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Williams, Roberta</i>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>3-15-85</i>                  |   |  | 2b. HOUR<br><i>3:00 P.M.</i>   |   |  |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>Black</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>5 18 13</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>71</i> YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>N. Carolina</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City, MD.</i>   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Provident Hospital</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><i>Maryland</i>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><i>Baltimore</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS / ZIP CODE<br><i>2734 W. Lafayette Avenue 21216</i>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Charlie L. Wimple</i>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Lottie Totten</i>  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>NO</i>                              |   |  |  |
| 16b. SOCIAL SECURITY NO.<br><i>219-12-7842</i>   |  |  | 17. INFORMANT ADDRESS<br><i>Russell Williams 2734 W. Lafayette Ave</i> |   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiac arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Respiratory Failure</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <i>Metastatic cancer</i> |  |  |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>minutes</i><br><i>1 hour</i><br><i>months</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>      |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3-11-85</i> to <i>3-11-85</i> , that (I) (we) last saw the deceased alive on <i>3-15-85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                               |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><i>Robert L. Brown</i>   |  |  | DEGREE   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><i>3-15-85</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Larry J. Perry M.D.</i>  |  |  | 22e. ADDRESS<br><i>107 E. Saratoga St. Suite 102</i>                   |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><i>BURIAL</i>   |  |  | 23b. DATE<br><i>3/20/85</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Balto. National Cem</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore, Md.</i> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Wm. March PH Inc. 1101 S. North Ave</i>   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><i>MAR 18 1985</i>              |  | 25b. REGISTRAR'S SIGNATURE<br><i>Walden-Rendell</i>                 |  |  |

BP



082040

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 2 6 0

REG. NO.

|   |  |   |  |   |  |  |
|---|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>THEOTIS WILLIAMS Jr.</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 2, 1985</b>  |   | 2b. HOUR<br><b>03:43am</b>   |  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>NEGROID</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3-26-47</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>37</b> YRS.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>South Carolina</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OR WORK FOR MOST OF WORKING LIFE)<br><b>Machine Operator Industry</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>BALTO.</b>  | 13c. CITY OR TOWN<br><b>BALTO.</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>THEOTIS WILLIAMS Sr.</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LYNA HARDY</b>  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>219-44-4166 3-31-72</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Lorraine Williams 6054 Marquette Rd.</b>                         |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Brainstem Hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Hypertension</b>   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 minutes</b><br><b>16 Hours</b><br><b>4-5 years</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a)   |  |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/2</b> 19 <b>85</b> to <b>3/2</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>3/2</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |   |  |   |  |  |
| 22b. SIGNATURE<br><b>James E. Greenwald</b>   |  | DEGREE<br><b>MD PHD</b>   |  | 22c. DATE SIGNED<br><b>3/2/85</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James Greenwald</b>   |  | 22e. ADDRESS<br><b>600 N WOLFE ST BALTIMORE, MD</b><br><b>Johns Hopkins Hospital</b>  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>3-6-85</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Carrisad Forest LA</b>                                 |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Calvin B. Scruggs</b>  |  | ADDRESS<br><b>1512 E. Preston</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 4 1985</b>  |  |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>                                      |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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20% cotton fiber

CHIFFON

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5

0 8 2 6 1

REG. NO.

|  |  |  |   |   |                            |  |   |  |  |
|--|--|--|---|---|----------------------------|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>DANTE WILSON</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3/23/85</b>                   |   | 2b. HOUR<br><b>7:40 AM</b> |  |   |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>BLACK</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 6 75</b>   |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>9</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1740 E. MADISON ST</b> |   |   |                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CHILD</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>   |  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN          |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HOWARD V WILSON</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SHARON B WRIGHT</b> |   |                            |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br>ADDRESS<br><b>JOHNS HOPKINS ONCOLOGY CENTER</b>  |                            |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute lymphocytic leukemia</b>  |  |  |   |   |                            |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>16 m</b>  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____  |  |  |   |   |                            |  |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____  |  |  |   |   |                            |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a   |  |  |   |   |                            |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                            |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/20</b> 19 <b>85</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I we) did (did not) view the body after death. |  |  |   |   |                            |  |   |  |  |
| 22b. SIGNATURE<br><b>David M Virshup</b> MD  |  |  |   |   |                            | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>3/23/85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DAVID M VIRSHUP, M.D.</b>  |  |  |   |   |                            | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>3/27/85</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arboretus mem PK</b>   |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arboretus Md.</b>   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Betts Funeral Home</b>  |  |  |   |   |                            | ADDRESS<br><b>1129 N. Caroline St</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 26 1985</b>  |  |
|  |  |  |   |   |                            | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |   |  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1. The first part of the document is a list of names and addresses. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

2. The second part of the document is a list of names and addresses, similar to the first part. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

3. The third part of the document is a list of names and addresses, similar to the first two parts. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

4. The fourth part of the document is a list of names and addresses, similar to the first three parts. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

5. The fifth part of the document is a list of names and addresses, similar to the first four parts. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

6. The sixth part of the document is a list of names and addresses, similar to the first five parts. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

7. The seventh part of the document is a list of names and addresses, similar to the first six parts. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

8. The eighth part of the document is a list of names and addresses, similar to the first seven parts. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

9. The ninth part of the document is a list of names and addresses, similar to the first eight parts. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

10. The tenth part of the document is a list of names and addresses, similar to the first nine parts. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|   |  |  |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ESTHER C. WILSON  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3/14/85 |   |  | 2b. HOUR<br>10 PM   |  |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan. 17, 1891   |  | 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br>94  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>YRS.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>West Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE CITY   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>4401 Roland Ave. 21210  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Tennyson Cundiff   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Catherine Mary Isaac   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>215-32-8458  |  | 17. INFORMANT<br>8 Thaxton Court<br>Roderic C. Wilson Timonium, Maryland 21093  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ASPIRATION PNEUMONIA</u><br><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>(1) INTRA CEREBRAL HEMMORRHAGE</u><br><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. |  |  |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>1 PM   |  |
|   |  |  |  |   |  |   |  |   |  |
|   |  |  |  |   |  |   |  |   |  |
|   |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 3/14, 1985, that (I) (we) last saw the deceased alive on 3/14, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>W Kent Davis  |  |  |  | DEGREE<br>MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>     |  |   |  | 22c. DATE SIGNED<br>3/14/85   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>W. KENT DAVIS  |  |  |  | 22e. ADDRESS<br>UNION MEMORIAL HOSPITAL   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>3/18/85   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Windemere Burial Park   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Huntington, Cabell, W. Va.                        |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212   |  |  |  | ADDRESS<br>6500 York Rd.  |  | DATE REC'D. BY REGISTRAR 3/18/85 REGISTRAR'S SIGNATURE  |  |   |  |



1950

UNITED STATES DEPARTMENT OF AGRICULTURE  
WASHINGTON, D. C. 20250  
OFFICE OF THE ASSISTANT SECRETARY FOR  
FOREIGN AFFAIRS  
BUREAU OF AGRICULTURAL AFFAIRS  
WASHINGTON, D. C. 20250  
JAN. 17, 1951  
TO: THE SECRETARY OF AGRICULTURE  
FROM: THE ASSISTANT SECRETARY FOR  
FOREIGN AFFAIRS  
SUBJECT: [Illegible]

[Illegible text block]

UNITED STATES DEPARTMENT OF AGRICULTURE  
WASHINGTON, D. C. 20250  
JAN. 17, 1951  
TO: THE SECRETARY OF AGRICULTURE  
FROM: THE ASSISTANT SECRETARY FOR  
FOREIGN AFFAIRS  
SUBJECT: [Illegible]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 2 6 3

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |  |  |  |  |   |  |  |
|---|--|--|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JAHAZEL WILSON</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-10-85</b>                                |  | 2b. HOUR<br><b>3:30 P</b>  |   |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 16 08</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.                 |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Smithfield, W. Va.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Ruthers Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Laborer</b>   |  | 12b. IND OF BUSINESS OR INDUSTRY                                  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE COUNTY CITY OR TOWN<br><b>Maryland Prince Geo. Hanham</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>5707 Lorraine Drive 20706</b>                   |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Wilson</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>LAST MIDDLE LAST<br><b>Rosie</b>                         |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-30-3181</b>   |  | 17. INFORMANT<br><b>Stanley Wilson-Hanham, Ind.</b>  |  |   | ADDRESS <b>5707 Lorraine Drive</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Shock</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Septicemia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pneumonia - Respiratory failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Renal Failure - Anemia - GI bleeding</b>   |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/28</b> , 19 <b>85</b> , to <b>3/10</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>3/10</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                  |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Buli T Duong</b>   |  |  |  | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   | 22c. DATE SIGNED<br><b>3/10/85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BICH T. DUONG</b>   |  |  |  | 22e. ADDRESS<br><b>LUTHERAN HOSPITAL</b>   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/14/85</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St Rose</b>   |  | 23d. LOCATION<br>(CITY OR TOWN) COUNTY STATE<br><b>Harmon MD</b>  |  |  |
| 24. FUNERAL DIRECTOR<br><b>M P Dayos 6387 G. / m / w</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 11 1985</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Hendall</i>       |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

11

Handwritten text, mostly illegible due to fading and bleed-through. Some words like "The" and "and" are visible.

Handwritten text, mostly illegible due to fading and bleed-through. Some words like "The" and "and" are visible.



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Vertical text, possibly a date or reference number, written in a stylized font. It appears to be "11/11/11".

074006

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>John Hines Wilson Sr.</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Mar. 12, 1985</b>                                  |   |  | 2b. HOUR<br><b>3P</b> M   |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12-15-14</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>122 E. Melrose Ave. - Apt. A</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Owner</b>                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Gardener</b>   |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>----</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>122 E. Melrose Ave. APT. A 21212</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas W. Wilson</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Helen Hines</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>--</b>   |  | 17. INFORMANT<br><b>John H. Wilson Jr.</b>  |  | ADDRESS<br><b>325 E. Timonium Road</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>ischemic heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>sudden</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>about 5 yrs</b> |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>no</b>  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>---</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>---</b>                               |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>---</b> P.M. <b>19</b>                 |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)<br><b>---</b>   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>322 St Paul</b> |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>322 St Paul Baltimore City MD</b>  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>about Dec 5/85</b> to <b>12/12/85</b> and that (in) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>William F. Runner</b>  |  |  | DEGREE<br><b>MD</b>  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>3/13/85</b>                                       |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Wm. F. Runner</b>   |  |  | 22e. ADDRESS<br><b>322 St Paul St 21218</b>  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  |  | 23b. DATE<br><b>3-13-85</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home 6500 York Road 21212</b>   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 13 1985</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                         |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|   |  |  |  |   |                       |   |  |   |  |
|---|--|--|--|---|-----------------------|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Eva V. Wingate  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 27 1985 |   | 2b. HOUR<br>2:05 A.M. |   |  |   |  |
| 3. SEX<br>Femlae  |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3-28-1907   |                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 yrs. YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>XX Baltimore City MD.                                   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Union Memorial Hospital |  |   |                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |                       |   |  |   |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>Balto.  |  | 13c. CITY OR TOWN<br>Balto.   |                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Shultz   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret Cann  |                       |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>- 216-12-0057  |  | 17. INFORMANT<br>ADDRESS<br>Dorothy C. Gann 125 E. Fort Ave. 21230  |                       |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Atherosclerotic Coronary Artery Disease</u>               |  |  |  |   |                       |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Cardiac arrhythmias</u>  |  |  |  |   |                       |   |  |   |  |
| 19a. DATE OF OPERATION<br>-   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>-  |  |   |                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                       |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                       |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/1/85</u> to <u>3/27/85</u> , that (I) (we) lost<br>saw the deceased alive on <u>3/27/85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |                       |   |  |   |  |
| 22b. SIGNATURE<br>Betsy A. Fay  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                       |   |  | 22c. DATE SIGNED<br>3/27/85   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Betsy A. Fay   |  |  |  | 22e. ADDRESS<br>Union Memorial Hospital   |                       |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>3-30-85   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cem.   |                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Md.                                       |  |   |  |
| 24. FUNERAL DIRECTOR<br>Schimunek Funeral Home, Inc.<br>3331 Brehms Lane, Balto., Md. 21213   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 29 1985  |                       | 25b. REGISTRAR'S SIGNATURE  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |   |   |   |  |
|---|--|---|--|---|--|---|---|---|--|
| DECEASED NAME<br>(TYPE OR PRINT) <b>PEARL J. WINSTON</b>  |  |   | 7a. DATE OF DEATH<br>MONTH DAY YEAR <b>MARCH 1, 1985</b> |   | 7b. HOUR<br><b>4:55 AM</b>   |   |   |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>6 3 1900</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.                                 |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Kentucky</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                 |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secour Hospital</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Nurse</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Pvt. Duty</b>   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>BALTO</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE <b>1909 Woodlawn Dr. Baltimore, Maryland 21207</b> |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Josie Johnson</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bessie Johnson</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No.</b> 16b. SOCIAL SECURITY NO. <b>217-30-4660</b> 17. INFORMANT <b>Mrs. Helen Martin</b> ADDRESS <b>105 Saunders Court Louisville, Kentucky 40211</b> |  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ph. ca</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>cup + partial aspir</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |   |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>        |   | 20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)  |  |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |   |   |  |
| 22b. SIGNATURE<br><i>Helen M. Saunders</i>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   |   | 22c. DATE SIGNED<br><b>3/4/85</b>                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Rolando A. Saunders</b>   |  |   |  | 22e. ADDRESS<br><b>Bon Secour Hospital</b>  |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  | 23b. DATE<br><b>3/6/1985</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>          |   |   |  |
| 24. FUNERAL DIRECTOR'S NAME<br><b>Funeral Home Inc. Baltimore, Maryland 21216</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 6 1985</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>                        |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 08267

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JULIUS EWALD WISCH</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03 02 85</b>  |  | 2b. HOUR<br><b>6:45P M</b>                                      |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 25 04</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                            | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                            |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1037 ROCK HILL AVENUE, 21229</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>GOV'T EMPLOYEE</b>    |   |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. GOV'T</b>                                  |  |   |   |  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |   |   |  |   |
| 13a. STATE<br><b>MARYLAND</b>   | 13b. COUNTY<br><b>--</b>   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>1037 ROCK HILL AVENUE, 21229</b>                        |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JULIUS C. WISCH</b>                        |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>NATALIE SEMICOTT</b>                        |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>       |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-03-7286</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>KATHRYN BOBET WISCH 21229</b><br><b>1037 ROCK HILL AVENUE</b> |   |

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*Cardiac Arrest*APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH*5 minutes*

DUE TO, OR AS A CONSEQUENCE OF

(b)

*Acute Myocardial Infarction**15 minutes*

DUE TO, OR AS A CONSEQUENCE OF

(c)

*Arteriosclerotic Cardiovascular Disease**10 years*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

*Congestive Heart Failure and Old Stroke*

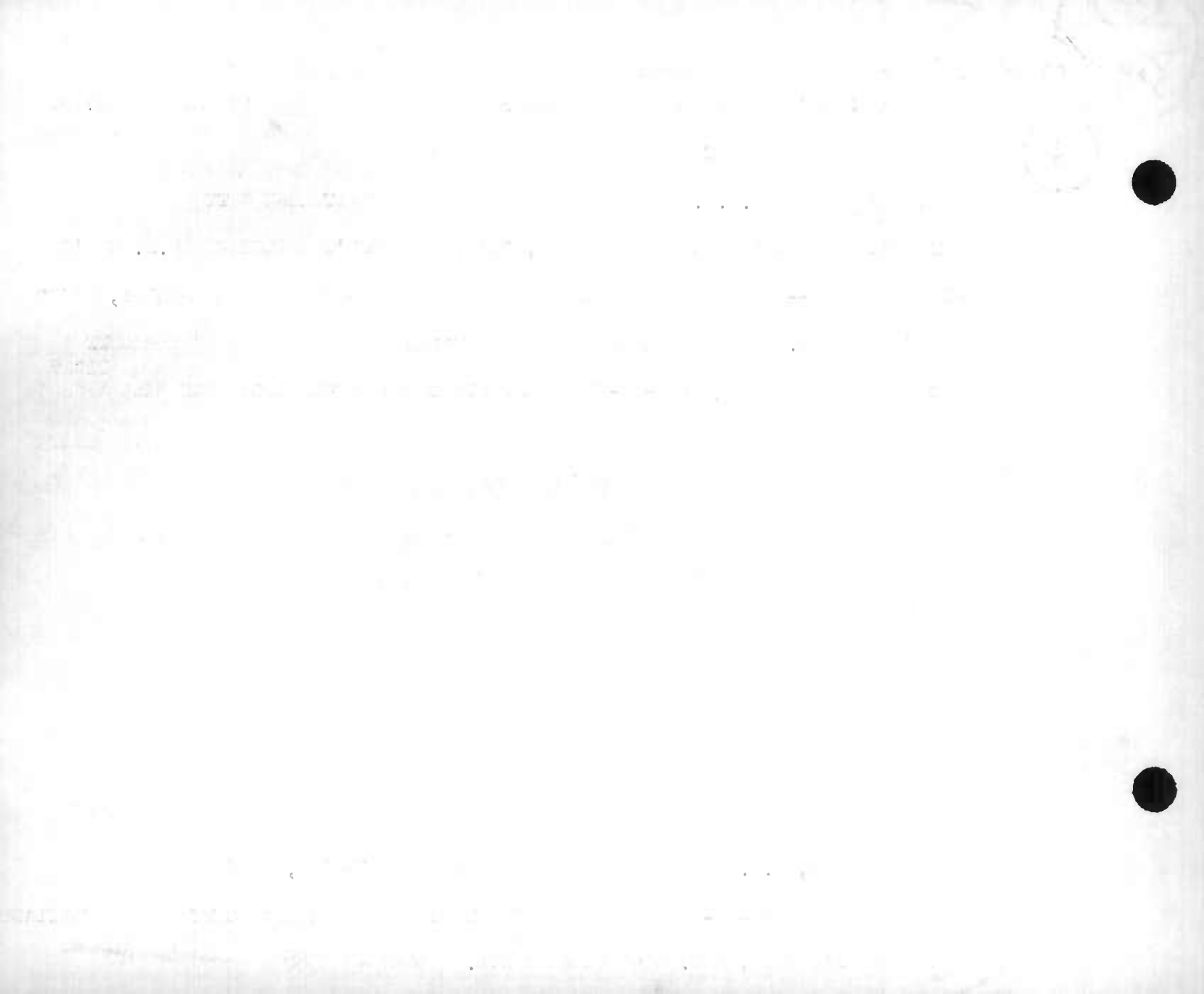
|   |  |  |  |   |   |
|---|--|--|--|---|---|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |
| 22b. SIGNATURE<br><i>Jeffrey Cole, M.D.</i>   |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>3/8/85</b>   |   |
| 22d. PHYSICIAN (NAME AND ADDRESS)<br><b>JEFFREY COLE, M.D.</b>  |  | 22e. ADDRESS<br><b>3455 WILKENS AVENUE, 21229</b>                      |  |   |   |

|   |                              |   |  |
|---|------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                               | 23b. DATE<br><b>03-05-85</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WESTERN CEMETERY</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.</b> |                              | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 4 1985</b>            | 25b. REGISTRAR'S SIGNATURE<br><i>Davidson-Randall</i>                        |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

6 5 0 8 2 6 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |   |  |  |  |   |  |
|---|--|--|---|---|---|--|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>ROSE Scholastica Witt</b>   |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br><b>March 5, 1985</b>                     |   |   | 2b HOUR<br><b>1:59P<sup>M</sup></b>  |  |  |   |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>White</b>   |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 4 08</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b>  |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 72 HRS<br>HOURS MIN.  |   |  |
| 8 BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 9a CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 9b MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital</b> |   |   |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>  |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Martin-Marietta</b>   |   |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>Maryland</b>   |  |  | 13b COUNTY  |   | 13c CITY OR TOWN<br><b>Baltimore</b>  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS / ZIP CODE<br><b>320 Elrino Street 21224</b> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Emanuel Rajnisz</b>   |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br><b>Anna Zienkiewicz</b>          |   |   |  |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |  |  | 16b SOCIAL SECURITY NO.<br><b>216-14-8449</b>                               |   | 17 INFORMANT ADDRESS<br><b>Carl Bastio 7811 Highpoint Road 21234</b>          |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLUS SUSPECTED</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>PERIPHERAL VASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <b>CHRONIC ATRIAL FIBRILLATION</b>                      |  |  |   |   |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>ASPIRATION</b>   |  |  |   |   |   |  |  |  |   |  |
| 19a DATE OF OPERATION   |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>            |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |  |   |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)       |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>February 24, 1985</b> to <b>March 5, 1985</b> , that (I) (we) last saw the deceased alive on <b>March 5, 1985</b> , and that in (me) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |   |  |  |  |   |  |
| 22b SIGNATURE<br><b>L.K. Peredo</b>   |  |  | DEGREE  |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c DATE SIGNED<br><b>3/5/85</b>                                |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>L.K. PEREDO, M.D.</b>  |  |  | 22e ADDRESS<br><b>CHURCH HOSPITAL<br/>100 N. BROADWAY, BALTO., MD 21231</b> |   |   |  |  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b DATE<br><b>3-8-85</b>   |   | 23c NAME OF CEMETERY OR CREMATORY<br><b>St. Stanislaus Cemetery</b>           |  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City, Maryland</b>   |   |  |
| 24 FUNERAL DIRECTOR<br>(NAME)<br><b>Charles S. Zeiler &amp; Son Inc.</b>  |  |  |   |   | 25a DATE REC'D. BY REGISTRAR<br><b>MAR 07 1985</b>                            |  | 25b REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randell</b>                                     |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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Belgium

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Belgium City

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200 Belium Street 1924

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOSEPHINE R. WOLF</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 22 85</b>                               |  | 2b. HOUR<br><b>6:45 PM</b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Cauc.</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2/11/17</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.                              | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pa.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> MD.                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE CITY</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Operator</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>P Tele-phone Co.</b>                   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>  |   |   | 13b. COUNTY<br><b>-</b>   | 13c. CITY OR TOWN<br><b>Balto.</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank Sims</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Unknown</b>                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>218-10-0183</b>  |   | 17. INFORMANT ADDRESS<br><b>Robert Wolf, same address</b>                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pancreatic Cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/22</b> , 19 <b>85</b> , to <b>3/22</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>3/22</b> , 19 <b>85</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did not view the body after death.   |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Robert Vissing</b>  |   | DEGREE<br><b>MO</b>   |   | 22c. DATE SIGNED<br><b>3/22/85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT VISSING</b>   |   | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>3/25/85</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>               |  |
| 24. FUNERAL/DIRECTOR<br><b>Schimmunek Funeral Home, Inc.</b><br><b>3331 Brehms Lane, Balto., Md. 21213</b>   |   |   |   | 25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>MAR 26 1985</b>  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |   |   |  |  |   |
|--|--|---|--|--|---|---|--|--|---|
| FOR<br>STATE<br>REGISTRAR  |  |   |  |  | REG. NO.  |   |  |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>RUTH WOLFSON</b>  |  |   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 16 85</b>                 |   |  | 2b. HOUR<br><b>9:58 PM</b>   |   |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 14 14</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW YORK</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL OF BALTIMORE</b> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CLERK</b>                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. GOV'T</b>   |   |
| 13a. STATE<br><b>MD.</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTO.</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>#21209 2806 SMITH AVE</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MAX WOLFSON</b>   |  |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANNIE SHAPIRO</b> |   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>129-12-4135</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>REUBEN WOLFSON 2806 SMITH AVE. ( 21209)</b>   |   |   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b>   |  |   |  |  |   |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>IMMEDIATE</b> |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>MYOCARDIAL INFARCTION</b>  |  |   |  |  |   |   |  |  | <b>IMMEDIATE</b>  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |  |  |   |   |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>ANGINA</b>  |  |   |  |  |   |   |  |  |   |
| 19a. DATE OF OPERATION<br><b>N/A</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |   |   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/16</b> , 19 <b>85</b> , to <b>3/16</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>3/16</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |  |   |   |  |  |   |
| 22b. SIGNATURE<br><b>Fred B. Sumner MD</b>   |  |   |  |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>3/16/85</b>                     |  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>FRED B. SUMNER, MD</b>   |  |   |  |  | 22e. ADDRESS<br><b>SINAI HOSPITAL BUILDING AT GREENSPRING</b>         |   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>CREMATION</b>   |  | 23b. DATE<br><b>3/18/85</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WESTVIEW MEMORIAL PARK</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>CATONSVILLE. BALTO., MD.</b>                   |  |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BRO S.</b>   |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 22 1985</b>                   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Arthur J. Rindler</i> |  |   |
| 6010 REISTERSTOWN RD. BALTO., MD. ( 21215)   |  |   |  |  |   |   |  |  |   |

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |   |   |
|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>William Wolfson   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 30 85  |   | 2b. HOUR<br>10 AM   |
| 3. SEX<br>MALE   | 4. RACE<br>WHITE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>09 10 10  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.                                      |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>POLAND   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                      |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>OWNER | 12b. KIND OF BUSINESS OR INDUSTRY<br>DENTAL LAB                                 |
| 13a. STATE<br>MD   |   | 13b. COUNTY<br>Balt   | 13c. CITY OR TOWN<br>Balt   | 13d. INSIDE CITY LIMITS?<br>YES NO <input checked="" type="checkbox"/>          |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>SAMUEL WOLFSON   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ESTHER CITREN  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO |   | 16b. SOCIAL SECURITY NO.<br>216-10-1886   |   | 17. INFORMANT<br>ADDRESS<br>21209<br>MRS. BLANCHE WOLFSON 6505 SANZO RD., APT A |

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardio pulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Metastatic Cancer

DUE TO, OR AS A CONSEQUENCE OF

(c)

Rt foot gangrene

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Rt iliac art

MEDICAL CERTIFICATION

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (the hospital) attended the deceased from 3/30/85 to 3/30/85, that (I) (we) last saw the deceased alive on 3/30/85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |
| 22b. SIGNATURE<br>Shari Sopher MD  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>3/30/85  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SHARI SOPHER  |  | 22e. ADDRESS<br>SINAI HOSP  |  |  |  |

|   |                      |  |   |
|---|----------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  | 23b. DATE<br>3/31/85 | 23c. NAME OF CEMETERY OR CREMATORY<br>BETH JACOB CEM | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>FINKSBURG, CARROLL MARYLAND |
| 24. FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO, MD 21215 |                      |  | 25a. DATE REC'D BY REGISTRAR<br>APR 4 1985                                |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

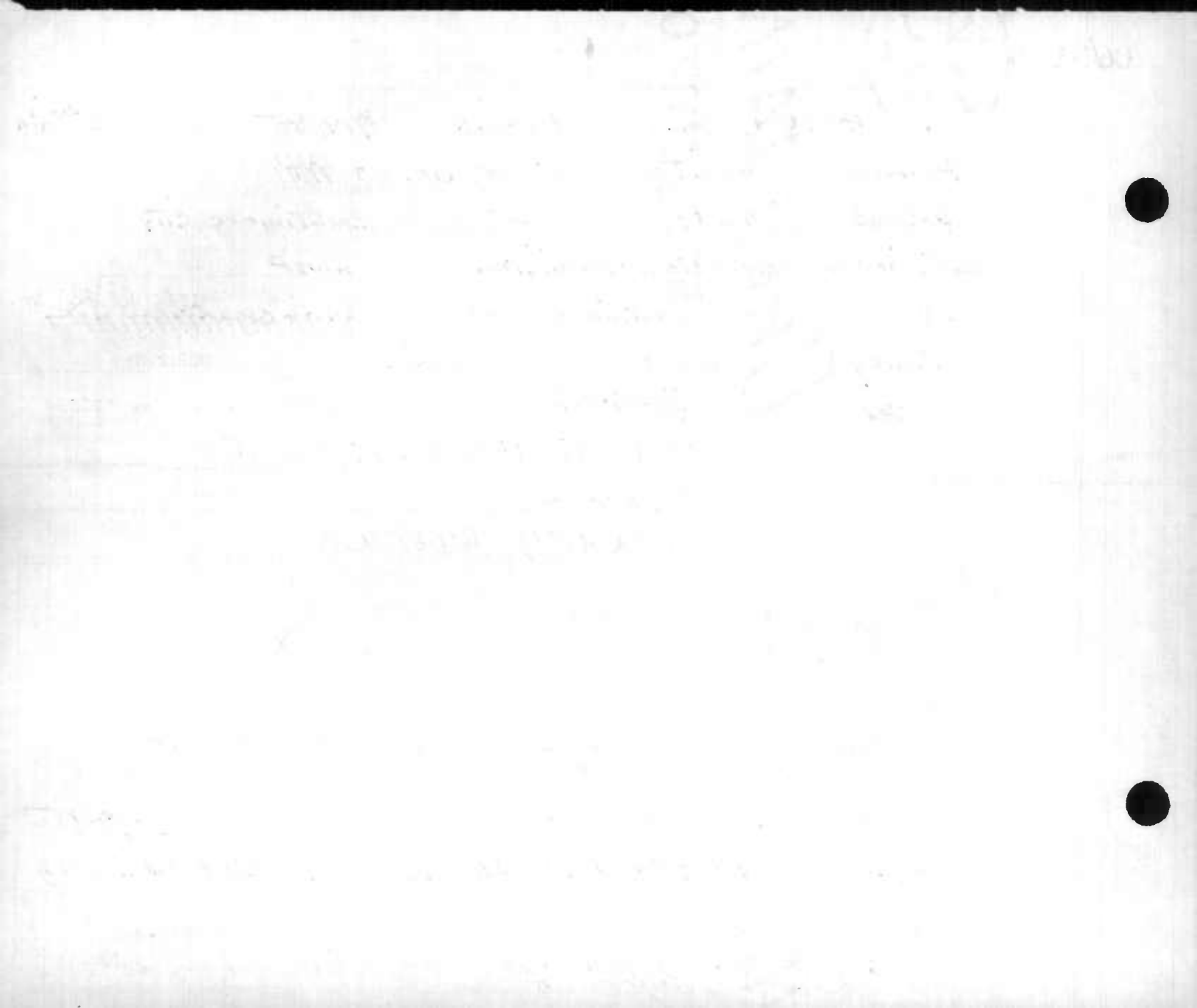
|  |  |  |  |   |  |   |  |  |
|--|--|--|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Helen M. Wolosik  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3/19/85 |   |  | 2b. HOUR<br>5:25 AM   |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 15 1901   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 8/4/1 YRS.  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Poland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Meridian-Hamilton |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HWSF                        |  |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Stanley Tomaszewski  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Marie Unknown  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-09-9133<br>A12-99-301B  |  | 17. INFORMANT<br>ADDRESS<br>Lucille M Pippin 1714 Redwood Ave 21234   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE (HIGH OUTPUT)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ANEMIA<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) URINARY BLEEDING<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |
| 22a. I certify that (I) [this hospital] attended the deceased from 03-11-1985 to 03-18-1985, that (I) (we) lost<br>saw the deceased alive on 03-18-1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |
| 22b. SIGNATURE<br>CESAR G. GAMBORA M.D.<br>DEGREE<br>ATTENDING PHYSICIAN   |  |  |  | 22c. DATE SIGNED<br>3-19-85   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CESAR G. GAMBORA M.D.                                  |  |  |
| 22e. ADDRESS<br>3440 BEAVER RD. BALD. MD. 21213  |  |  |  |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>3/21/85   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                               |  |  |
| 24. FUNERAL DIRECTOR<br>Leonard J. Ruck Inc. Baltimore, Maryland   |  |  |  | 25a. DATE RECEIVED BY REGISTRAR<br>MAR 21 1985  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP  
DHMH - 16 60M 7/84  
(VRA 15, 4)

082045

1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |
|--|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST: Annie MIDDLE: S. LAST: Wood  |  |  | 2a. DATE OF DEATH<br>MONTH: 3 DAY: 9 YEAR: 85<br>2b. HOUR: M  |   |
| 3. SEX<br>female   | 4. RACE<br>black   | 5. DATE OF BIRTH<br>MONTH: 3 DAY: 31 YEAR: 21  |   | 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br>64 YRS                              |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>MD   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                 |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>749 Bartlett Avenue |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>12b. KIND OF BUSINESS OR INDUSTRY |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |   |   |
| 13a. STATE<br>MD   | 13b. COUNTY  | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |   |
| 14. FATHER'S NAME<br>FIRST: Donald MIDDLE: Boyce LAST: Boyce   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST: Wilhelmina MIDDLE: Griffith LAST: Griffith  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>219-28-6288  |   | 17. INFORMANT<br>ADDRESS: Sylvira Wood 6056 Moravia Park Dr.              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Gastric cancer with metastases to liver</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____   |  |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   |   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |   |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that (1) (this hospital) attended the deceased from <u>Feb 21</u> , 19 <u>85</u> , to <u>March 7</u> , 19 <u>85</u> , that (1) (we) last saw the deceased alive on <u>March 7</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. |   |   |
| 22b. SIGNATURE<br><u>Chi-Shiang Chen</u>   |  | DEGREE<br><u>MD</u><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |   | 22c. DATE SIGNED<br>3/11/85   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Chi-Shiang Chen, M.D.   |  | 22e. ADDRESS<br>100 N. Broadway Balto., MD 21231   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>3/15/85   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cem.                      |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD   |  | 24. FUNERAL DIRECTOR<br>NAME: Wm. C. March F/H ADDRESS: 1101 E. North Ave.   |   |   |
| 25a. DATE REC'D. BY REGISTRAR<br>MAR 12 1985   |  | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson Handell</u>   |   |   |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |  |                                   |
|--|--|--|---|--|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | 2a. DATE OF DEATH  |   | 2b. HOUR   |                                   |
| Nancy M. Woodfield   |  | 03 03 85   |   | 5:30 A   |                                   |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                               | 7. UNDER 1 YEAR  |                                   |
| FEMALE   | WHITE  | 10 17 03   | 81  | MONTHS DAYS HOURS MIN.   |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |                                   |
| SCOTLAND   | USA  |  | Baltimore City MD.  |  |                                   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore  | Sinai Hospital   |  | HOMEMAKER   |  | HOME                              |
| 13a. STATE   | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. STREET ADDRESS / ZIP CODE                                |  |                                   |
| MD   | 21211  | BALTIMORE  | 3939 ROLAND AVENUE 21211                                      |  |                                   |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |   |  |                                   |
| JOHN DUNDAS  |  | MARGARET THOMSON   |   |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS  |                                   |
| NO   |  | 218-46-0514  |   | ALICE STEINBACH 3 LONGWOOD RD. 21210   |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |   |  |                                   |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>   |  |  |   |  |                                   |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____   |  |  |   |  |                                   |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |  |   |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Breast Carcinoma</u>   |  |  |   |  |                                   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |                                   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |   |  |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/2/85</u> , 19 <u>85</u> , to <u>3/3</u> , 19 <u>85</u> , that (I) (we) lost <u>3/3</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |  |                                   |
| 22b. SIGNATURE   |  | DEGREE   |   | 22c. DATE SIGNED   |                                   |
| George F. Gonzalez   |  | MD   |   | 3/3/85   |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |   |  |                                   |
| George F. Gonzalez   |  | Sinai Hospital   |   |  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                   |
| CREMATION  |  | MARCH 4, '85   |   | GREEN MOUNT CEMETERY BALTIMORE, MARYLAND                                       |                                   |
| 24. FUNERAL DIRECTOR NAME  |  | ADDRESS  |   | 25a. DATE REC'D. BY REGISTRAR  |                                   |
| WILLIAM E. JOHNSON   |  | 8521 LOCH RAVEN BLVD.  |   | MAR 4 1985   |                                   |
|  |  |  |   | 25b. REGISTRAR'S SIGNATURE   |                                   |
|  |  |  |   | John Davidson-Randall  |                                   |

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in accordance with the law.

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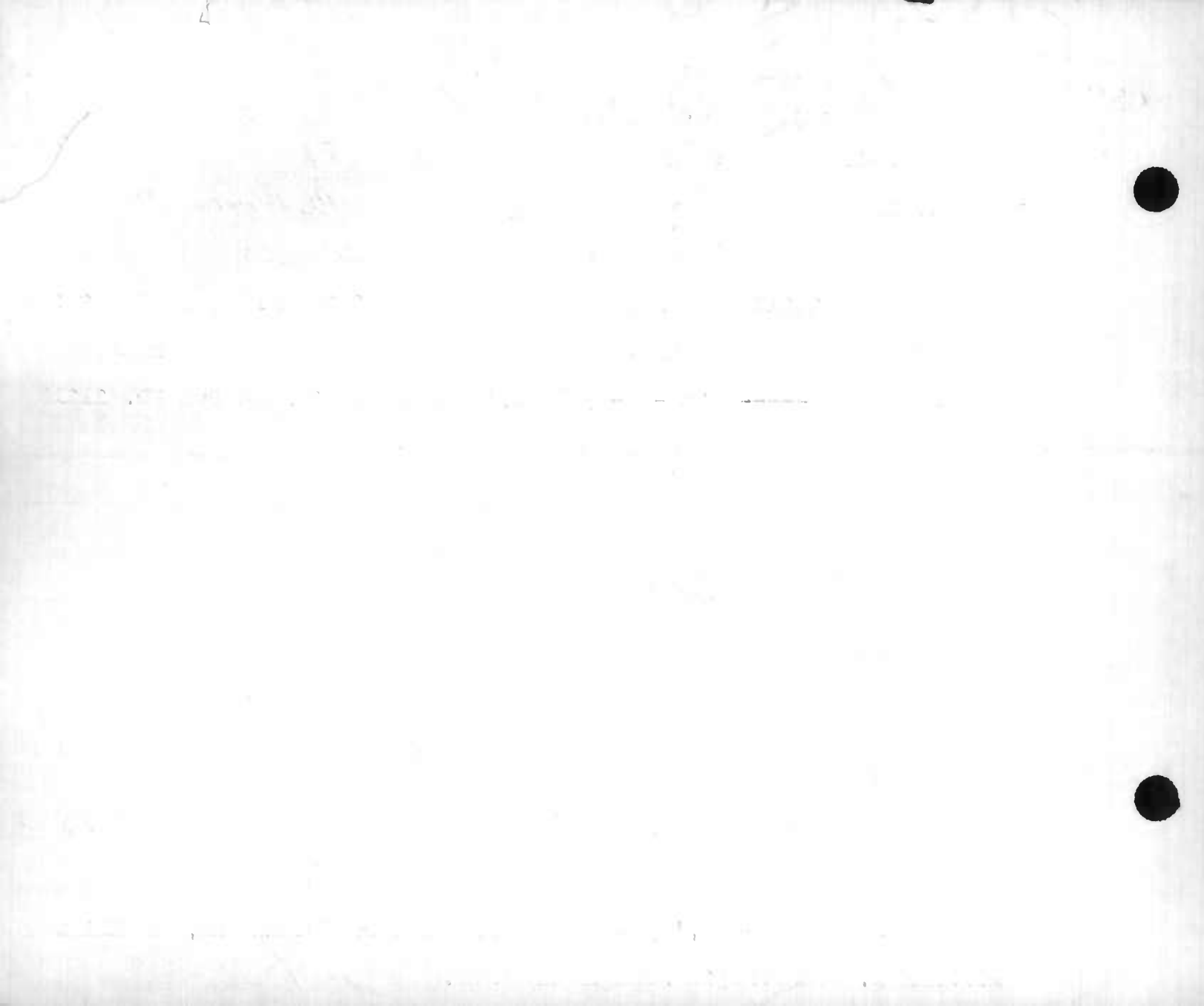
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|  |  |   |  |   |  |   |  |                                   |  |                  |  |
|--|--|---|--|---|--|---|--|-----------------------------------|--|------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | 2a. DATE OF DEATH   |  | MONTH   |  | DAY   |  | YEAR                              |  | 2b. HOUR         |  |
| NATHANIEL  |  | WOODS   |  | 3   |  | 6   |  | 85                                |  |                  |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR                   |  | IF UNDER 24 HRS. |  |
| MALE   |  | BLACK   |  | MONTH DAY YEAR<br>3 31 34   |  | 50  |  | MONTHS DAYS                       |  | HOURS MIN.       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |                                   |  |                  |  |
| TRINIDAD   |  | B.W.I.  |  |   |  | BALTIMORE   |  |                                   |  |                  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |                  |  |
| BALTO.   |  | UNION MEMORIAL HOSPITAL   |  |   |  | TAILOR  |  |                                   |  |                  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)          |  |   |  |   |  |   |  |                                   |  |                  |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS               |  | 21239            |  |
| MD.  |  |   |  | BALTO.  |  |   |  | 2011 SWANSEA RD.                  |  |                  |  |
| 14. FATHER'S NAME  |  |   |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |                                   |  |                  |  |
| FIRST MIDDLE LAST<br>ISSAC WOODS   |  |   |  | FIRST MIDDLE LAST<br>VICTORIA WOODS   |  |   |  |                                   |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) |  |   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS   |  |                                   |  |                  |  |
| NO   |  |   |  | 214-62-2963   |  | THERESA WOODS 2011 SWANSEA RD.  |  |                                   |  |                  |  |

IMMEDIATE CAUSE (o)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

## MEDICAL CERTIFICATION

19. DATE OF OPERATION

196 CONDITION FOR WHICH OPERATION WAS PERFORMED

200 AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

|                     |      |       |     |      |
|---------------------|------|-------|-----|------|
| 21b. TIME OF INJURY |      |       |     |      |
| HOUR                | A.M. | MONTH | DAY | YEAR |
|                     | P.M. |       |     | 19   |

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE  
AT WORK AT WORK

21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

| 211. LOCATION |              |        |       |
|---------------|--------------|--------|-------|
| STREET        | CITY OR TOWN | COUNTY | STATE |
|               |              |        |       |

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) lost  
saw the deceased alive on 2/18 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22 ADDRESS

23b. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

|               |   |        |       |
|---------------|---|--------|-------|
| 23d. LOCATION |   |        |       |
| CITY OR TOWN  | M | COUNTY | STATE |

Funeral Director

\_\_\_\_\_

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

NAME ADDRESS  
LEROY O. DYETT 4600 LIBERTY HGTS. AVE.

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 50M 4/B2  
(VRA 15. 4)



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100% COTTON

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |   |  |   |  |
|---|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Gertrude N. Woodson  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3-8-85 830 P.M.          |  |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Negro  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 17 03  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.<br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                        |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Kenasaw Nursing Home |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD. |   |  |
| 13a. STATE<br>Maryland  |  |   | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Baltimore                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles A. Hite   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Nunnie William |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |   | 16b. SOCIAL SECURITY NO.<br>216-0965-45                         |  | 17. INFORMANT<br>GARY STARGILL 12500 WOODSPRING |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac Arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac Respiratory Insufficiency<br>DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 min<br>16 days |  |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.<br>Arteriosclerotic Heart Disease   |  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/18/79 to 3/8/85, that (I) (we) last saw the deceased alive on 3/8/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |  |   |  |
| 22b. SIGNATURE<br>E. O. MONT J. MD  |  |   | DEGREE<br>M.D.  |  | 22c. DATE SIGNED<br>3/8/85                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>E. O. MONT J. MD   |  |   | 22e. ADDRESS<br>2300 Garrison Blvd 21216                        |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL   |  | 23b. DATE<br>3/13/85  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>King Memorial Park   |   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Randallstown, Md.   |  | 23e. DATE REC'D. BY REGISTRAR<br>MAR 11 1985  |   | 23f. REGISTRAR'S SIGNATURE<br>John Anderson-Randall  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Wm C March F/H Inc. 1101 E North Avenue   |  |   |   |  |   |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the study and the objectives of the research.

2. The second part of the report is a detailed description of the methodology used in the study. It includes information about the sample size, the data collection methods, and the statistical analysis techniques.

3. The third part of the report is a discussion of the results of the study. It presents the findings of the research and compares them with the previous studies in the field.

4. The fourth part of the report is a conclusion and a list of references. The conclusion summarizes the main findings of the study and provides recommendations for future research. The references list the sources of information used in the study.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85

08277

REG. NO.

1- FOR  
STATE  
REGISTRAR

098090

|   |  |   |  |   |  |   |  |   |  |  |  |  |  |  |  |
|---|--|---|--|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARLE</b>                                  |  | FIRST <b>WRIGHT</b>   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>3 31 85</b>  |  |  |  | 2b. HOUR<br><b>4:20 A M</b>  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>NEGRO</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 9 88</b>   |  | 6. AGE (IN YEARS, LAST BIRTHDAY)<br><b>77</b> YRS.                |  |   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                 |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |  |   |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hosp.</b> |  |   |  |   |  |   |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Custodian</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>School</b> |  |
| 13a. STATE<br><b>MD</b>   |  |   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BALTO</b>                                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3422 Holmes Ave 21227</b> |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>John</b> MIDDLE LAST                                |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MINNIE</b> MIDDLE LAST <b>Tolson</b>   |  |   |  |   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  |   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>ADDRESS<br><b>Goldie Wright 3422 Holmes Ave</b>  |  |   |  |  |  |  |  |  |  |

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**CARDIOPULMONARY ARREST**

DUE TO, OR AS A CONSEQUENCE OF

(b)

**PULMONARY Embolus**

DUE TO, OR AS A CONSEQUENCE OF

(c)

**FRACTURED HIP**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**90 mins.****one week****12 days**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

**Hypertension**

MEDICAL CERTIFICATION

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION<br><b>3/21/85</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>FRACTURED HIP</b>              |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR <b>3 P.M.</b> MONTH DAY YEAR<br><b>3-19-1985</b>          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>Subject fell.</b>                                     |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>home</b> |  | 21f. LOCATION<br>STREET<br><b>3422 Holmes Ave.</b>   |  | CITY OR TOWN<br><b>Balto.</b>   |  |
|   |  |   |  | COUNTY<br><b>MD.</b>   |  | STATE   |  |
| 22a. I certify that (this hospital) attended the deceased from <b>3/19</b> to <b>3/31</b> , 19 <b>85</b> , that (we) lost<br>saw the deceased alive on <b>3/31</b> , 19 <b>85</b> , and that in time (and place) between the date and hour and from the causes stated<br>above, (we) (did) (not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Stephen M. Seabron M.D.</b>  |  | DEGREE<br><b>MD.</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3/31/85</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>STEPHEN M. SEABRON</b>  |  | 22e. ADDRESS<br><b>Provident Hospital, Balt., Md.</b>                                 |  |  |  |   |  |

|   |  |                                   |  |  |  |  |  |
|---|--|-----------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>4/3/85</b>        |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. CALVARY</b> |  | 23d. LOCATION<br>CITY OR TOWN<br><b>A. A. County, MD</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Lockett Funeral Home</b>   |  | ADDRESS<br><b>1304 N. Conhalt</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 2 1985</b>       |  | 25b. REGISTRAR'S SIGNATURE<br><b>Davidson-Randall</b>    |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be prepared for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 08278

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FOR  
STATE  
REGISTRAR

REG. NO.

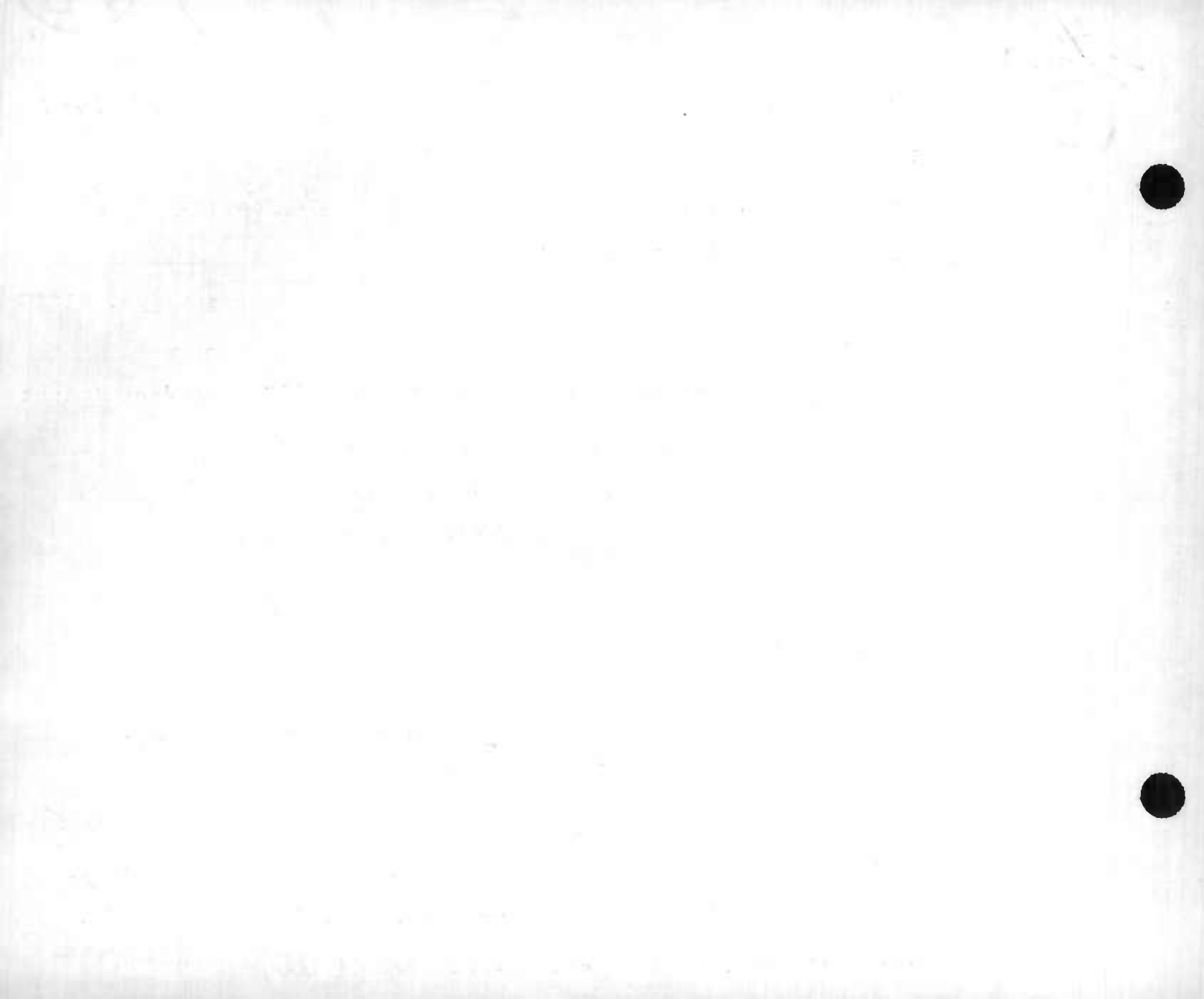
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|---|--|---|--|---|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>WALTER H. WRIGHT SR  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>03 22 85  |   |  | 2b. HOUR<br>2:45 AM   |   |  |   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 28 01  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS.                                |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Georgia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore city MD.                |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>city   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bon Secours Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br>Maryland  |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Baltimore   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>1817 Edmondson Ave. 21223 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |   |  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  |   | 16b. SOCIAL SECURITY NO.<br>215-10-0215  |   | 17. INFORMANT ADDRESS<br>Delores France 1817 Edmondson Avenue                  |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>end stage renal failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>congestive heart failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>seizure disorder</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/6</u> 19 <u>85</u> , to <u>3/22</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>3/22</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |   |  |   |  |
| 22b. SIGNATURE<br>Kuang-Yen Huang M.D.  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br>3/23/85   |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>KUANG-YEN HUANG  |  |   | 22e. ADDRESS<br>Bon Secours Hosp   |   |  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL   |  |   | 23b. DATE<br>2/26/85   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mount Auburn Cem.                        |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.                                    |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm March F/H Inc. 1101 E North Avenue   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 26 1985                                   |   | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP



092070

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

BP \_\_\_\_\_

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 2 7 9

FOR  
1- STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Minnie c. Wudtee  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 26 85 |   |  | 2b. HOUR<br>1:30 PM   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 18 12   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N. Carolina   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Francis Scott Key Medical Ctr. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |   |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |  |
| 13e. STREET ADDRESS / ZIP CODE<br>639 S. Avondale Road 21222   |  |   |  |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Julius Marshall  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Polly Marshall   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>ADDRESS<br>Apt. 2<br>Pearlene Royster 4406 Moravia Rd.   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) cardiac arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 3/24 19 85, to 3/26 19 85, that (1) (we) last saw the deceased alive on 3/26 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>John P. Joyce  |  |   |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>3/26/85   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John P. Joyce   |  |   |  | 22e. ADDRESS<br>4940 Eastern Ave, Balt, MD 21224  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>3/30/85  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mount Auburn Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.  |  |
| 24. FUNERAL DIRECTOR<br>Wm C March F/H Inc. 1101 E North Avenue  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 28 1985  |  | 25b. REGISTRAR'S SIGNATURE<br>W. Harrison Randle  |  |

MEDICAL CERTIFICATION

8:55 AM



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 2 8 0

REG. NO.

0870591

FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST<br><i>LEWIS HOWARD Wyatt</i>  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>March 19 1985</i>  |  | 2b. HOUR<br><i>6:50 PM</i>  |  |
| 3. SEX<br><i>Male</i>   |  | 4. RACE<br><i>Black</i>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>8 18 1944</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>39 1/2</i> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>W. Virginia</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore City</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>North Charles Care Hospital</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Nursing Asst.</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>HOSPITAL</i>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>MD</i>   |  | 13b. COUNTY<br><i>Prge</i>  |  | 13c. CITY OR TOWN<br><i>Baltimore</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>HERBERT WYATT</i>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>BETTY CLARK</i>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>No</i>   |  |   |  |
| 16b. SOCIAL SECURITY NO.<br><i>228 58 2076</i>  |  | 17. INFORMANT ADDRESS<br><i>Mrs Dorothy Wyatt 625 Dumbarton Ave 21218</i>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Pulmonary edema, bilateral, severe</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <i>Bronchopneumonia, bilateral</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ |  |   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><i>Hepatic congestion - Acute Tubular necrosis of Kidney</i>   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><i>Joseph L. Russ M.D.</i> DEGREE   |  |   |  | 22c. DATE SIGNED<br><i>3/19/85</i>  |  | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22f. ADDRESS  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>BURIAL</i>   |  | 23b. DATE<br><i>3-24-85</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>NAZARENE BAPT CH CEM</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>CHARLOTTE COURT HOUSE VA</i>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>JOSEPH L. RUSS 2727 W. NORTH AVE</i> ADDRESS   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>MAR 22 1985</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

620000



James L. Hill 1852-1918

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATHFOR  
1- STATE  
REGISTRAR

REG. NO.

091119

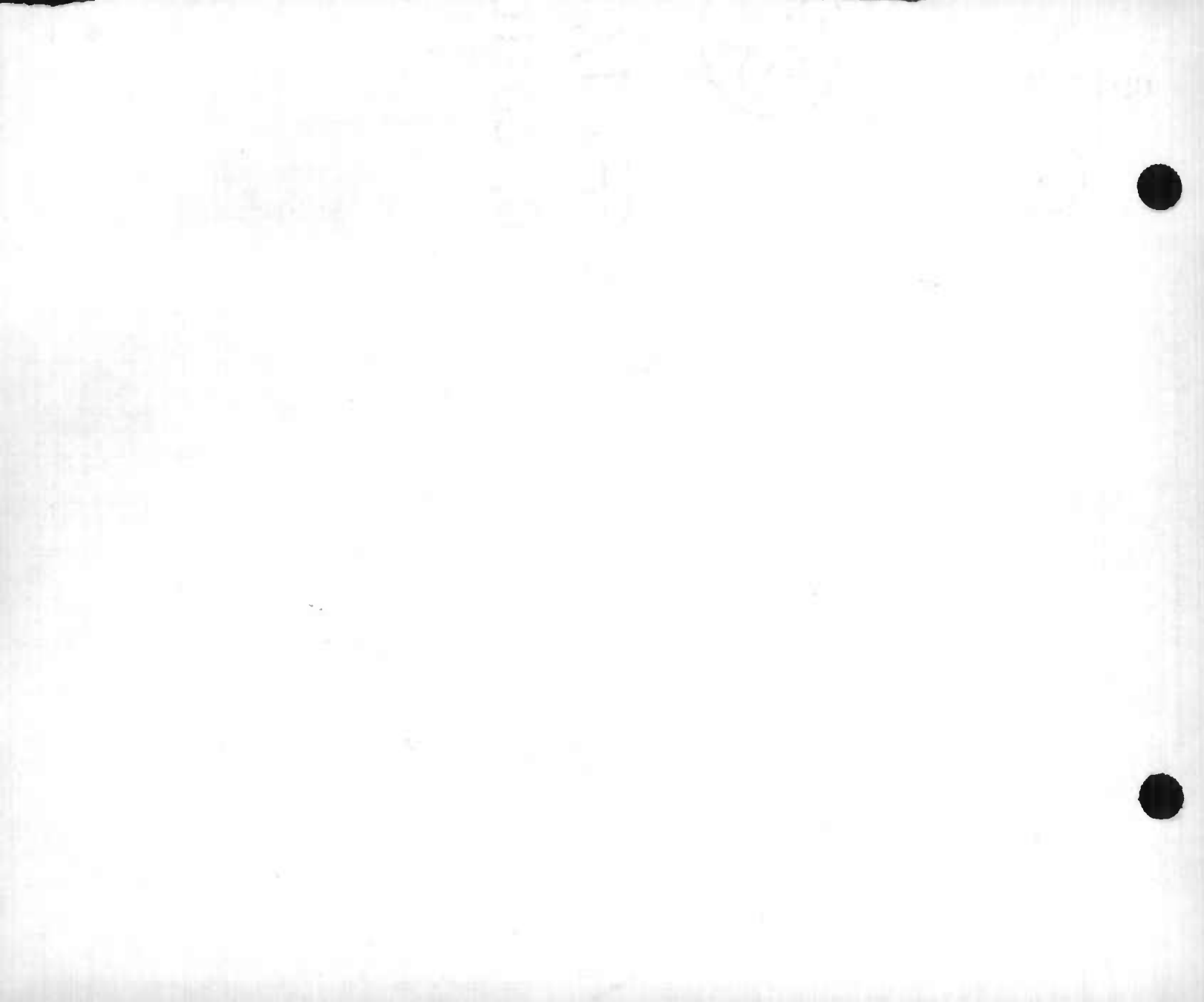
|  |  |   |  |   |   |   |   |  |  |
|--|--|---|--|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LILLIAN C YATES</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03-22-85</b>                 |   |   | 2b. HOUR<br><b>4:35PM</b>   |   |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 29 10</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b>  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>John L. Deaton Med. Cntr.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |   | 13e. STREET ADDRESS / ZIP CODE<br><b>1701 N. Eutaw Place 21217</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry Adams</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Josephine Cole</b>  |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br><b>Eliza Myers 1201 Kitmore Rd.</b>  |   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the breast metastatic</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Decubitus ulcers</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:   |  |   |  |   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept. 27</b> , 19 <b>84</b> , to <b>March 22</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>March 22</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.         |  |   |  |   |   |   |   |  |  |
| 22b. SIGNATURE<br><b>J. L. Keefe</b>   |  |   | DEGREE   |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED                             |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. L. KEefe</b>  |  |   | 22e. ADDRESS<br><b>5115 CHAS. BALTO. MD. 21230</b>                     |   |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>3/27/85</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>                 |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>  |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 27 1985</b>   |   |  |  |
| ADDRESS<br><b>1101 E. North Ave.</b>   |  |   |  |   |   | REGISTRAR'S SIGNATURE<br><b>J. L. Keefe</b>   |   |  |  |

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



083048

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 2 8 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |  |
|---|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <u>William</u> MIDDLE <u>Yipp</u> LAST <u>Yipp</u>                 |  |  | 2a. DATE OF DEATH<br>MONTH <u>3</u> DAY <u>10</u> YEAR <u>85</u>              |   | 2b. HOUR<br><u>1:09</u> M.                         |
| 3. SEX<br><u>M</u>  | 4. RACE<br><u>W</u>  | 5. DATE OF BIRTH<br>MONTH <u>7</u> DAY <u>01</u> YEAR <u>01</u>  |   | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><u>83</u> YRS.   | IF UNDER 1 YEAR<br>MONTHS <u>  </u> DAYS <u>  </u> |
| 7a. BIRTHPLACE<br>(COUNTRY)<br><u>USA</u>   | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Balt City</u> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Balt</u>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Lutheran</u> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>  </u> |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><u>  </u>  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE <u>MD</u> |  | 13b. COUNTY<br><u>Balt</u>   | 13c. CITY OR TOWN<br><u>Balt</u>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |  |
| 14. FATHER'S NAME<br>FIRST <u>  </u> MIDDLE <u>  </u> LAST <u>  </u>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>  </u> MIDDLE <u>  </u> LAST <u>  </u>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br><u>054185160</u>   |   | 17. INFORMANT<br>ADDRESS<br><u>Shirley Jones</u><br><u>313 Poplar St Baltimore MD</u><br><u>21216</u> |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

cardio pulm arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) sepsis

DUE TO, OR AS A CONSEQUENCE OF

(c)   APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   

MEDICAL CERTIFICATION

|  |   |   |   |
|--|---|---|---|
| 19a. DATE OF OPERATION<br><u>  </u>  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>  </u>                         | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>  </u> P.M. <u>  </u> <u>19</u> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)            |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><u>  </u>   | 21f. LOCATION<br>STREET <u>  </u> CITY OR TOWN <u>  </u> COUNTY <u>  </u> STATE <u>  </u> |   |
| 22a. I certify that (I) (this hospital) attended the deceased from<br>above, (I) (we) (did) (did not) view the body after death.<br><u>3/10/85</u> to <u>3/10/85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated |   |   |   |
| 22b. SIGNATURE<br><u>W. O. M. M.</u>   | DEGREE<br><u>  </u>   |   | 22c. DATE SIGNED<br><u>3/10/85</u>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Henry Ohlgen</u>   | 22e. ADDRESS<br><u>Lutheran Hosp.</u>   |   |   |

|   |                             |  |  |
|---|-----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  | 23b. DATE<br><u>3/16/85</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mt Zion</u>     | 23d. LOCATION<br>(CITY OR TOWN)<br><u>Baltimore MD</u> |
| 24. FUNERAL DIRECTOR<br>NAME <u>Althea L. M. (Kline)</u> ADDRESS <u>3207 W. 4th</u> |                             | 25a. DATE REC'D. BY REGISTRAR <u>MAR 12 1985</u>         |  |
|   |                             | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davis-Randall</u> |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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Received

of the sum of

20% COTTON

DAVEY & SONS

31st St. Spring  
Rochester N.Y.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 2 8 3

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |   |   |   |  |   |   |   |  |  |
|--|--|---|---|---|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Carrie Yoos</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 20, 1985</b>  |   |  | 2b. HOUR<br>M   |   |   |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>September 5, 1904</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS<br><b>80</b>                                   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                         |   |   | MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Home Maker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY         |  |  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>847 Benninghaus Rd 21212</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas Teichman</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Louise ?</b>  |  |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>218-05-6574</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs Doris Egan 2409 Ravenview Rd 21093</b>   |  |   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive C.V. Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |   |   |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.   |  |   |   |   |  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2) |   |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-80</b> , 19 <b>80</b> , to <b>3-15</b> , 19 <b>85</b> , that (I) (we) lost<br>saw the deceased alive on <b>3-13</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.    |  |   |   |   |  |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Jerome Gaber</b>  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  |   | 22c. DATE SIGNED<br><b>3-21-85</b>  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jerome Gaber M.D.</b>  |  |   | 22e. ADDRESS<br><b>5706 Bellona Ave Baltimore, Maryland</b>   |   |  |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>3/23/85</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>                    |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                        |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>   |  |   | ADDRESS   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 22 1985</b>                            |   | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson Randall</b>                                      |   |  |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |   |  |  |   |  |   |  |
|--|--|---|---|---|--|--|---|--|---|--|
| 1- FOR STATE REGISTRAR   |  |   |   |   | REG. NO.   |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Lillian G Yoos  |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>MARCH 17, 1985                             |  |   | 2b. HOUR<br>7:00 PM  |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>1 10 1910  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS  |   | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Hospital Corporation |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife           |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |   |   |   | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Dundalk              |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William Hartlove  |  |   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Sara Stevens                     |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>215-46-9271   |   | 17. INFORMANT<br>Jean S. Lacey  |  |  | ADDRESS<br>Same as 13e                    |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARCINOMA OF LUNG<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |   |   |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |   |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from MARCH 15, 1985, to MARCH 17, 1985, that (I) (we) last saw the deceased alive on MARCH 17, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.        |  |   |   |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br>Paul Gormley   |  |   |   |   | DEGREE<br>MD   |  | 22c. DATE SIGNED<br>3/17/85               |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PAUL GORMLEY   |  |
| 22e. ADDRESS<br>100 NORTH BROADWAY BALTIMORE, MD 31  |  |   |   |   | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                            |  |   |  |   |  |
| 23b. DATE<br>3/21/1985   |  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn                      |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                        |   |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>Duda-Ruck, Inc.<br>7922 Wise Avenue Dundalk, Maryland 21222   |  |   |   |   | 25a. DATE REC'D BY REGISTRAR<br>MAR 20 1985                                    |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature] |  |   |  |

EX-100



NOTICE

NOTICE

NOTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

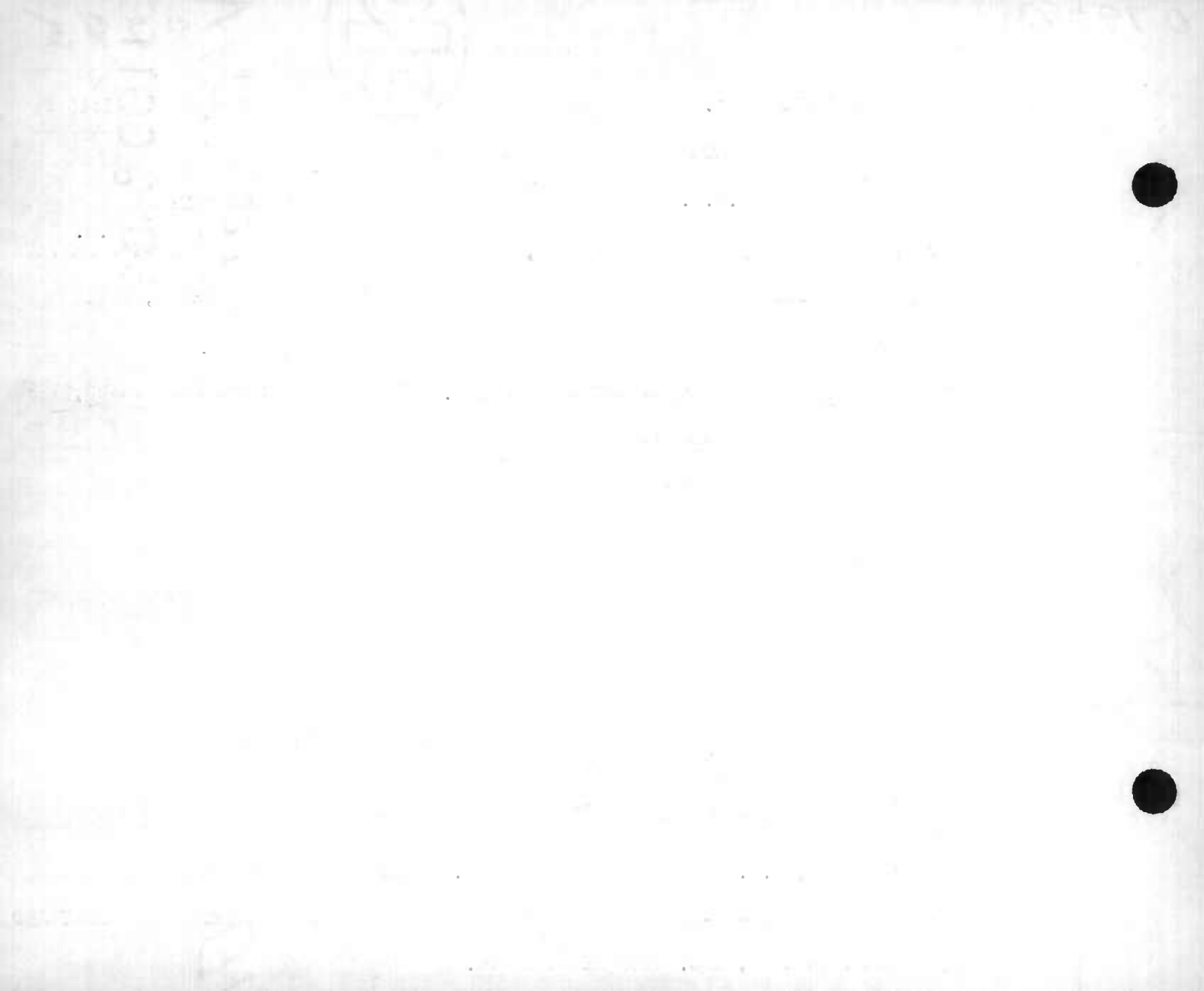
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |
|---|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WILLIAM A. ZAUN</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03 09 85</b> |   | 2b. HOUR<br><b>1:15 PM</b>                                   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 14 96</b>   |  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS.   |  | 7. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                       |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 9b. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                 |  | 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>504 OAKLAND AVENUE, 21212</b>   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MAILMAN</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. POSTAL SERVICE</b>   |  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13c. STREET ADDRESS / ZIP CODE<br><b>504 OAKLAND AVENUE, 21212</b>  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN ZAUN</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>                    |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>WW I 214-40-6146</b>                                |  | 17. INFORMANT<br>ADDRESS<br><b>EMORY G. KEARNS 2019 GRINNALDS AVENUE, 21230</b>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiovascular arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>dementia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 yrs</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |
| 21d. INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)             |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/5</u> 19 <u>85</u> to <u>Present</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>11/5</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.           |  |  |  |   |  |  |
| 22b. SIGNATURE<br><i>Juda Minkove</i>   |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>3/12/85</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JUDA MINKOVE, M.D.</b>  |  | 22e. ADDRESS<br><b>11 E. CHESTNUT HILL AVENUE</b>                                  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>03-13-85</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>   |  | 24b. ADDRESS<br><b>4107 WILKENS AVE.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 15 1985</b>   |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>Davidson-Randall</i>   |  | 25c. REGISTRAR'S NAME<br><b>DAVIDSON-RANDALL</b>                                   |  |   |  |  |

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

|  |  |  |  |   |   |  |   |  |  |
|--|--|--|--|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>IRMA ZALESKI WICZ</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>03-24-85</b>                    |   |   | 2b. HOUR<br><b>3:17 P.M.</b>   |   |  |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>C</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>12-04-38</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>46</b> YRS.                                    |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> MD                          |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SOUTH BALTIMORE GEN.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD</b>  |  |  | 13b. CITY OR TOWN<br><b>BALTIMORE</b>                                  |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS / ZIP CODE<br><b>1535 S. Charles St. 21230</b>                  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHARLES WHITE</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>EMMA ZEIBOLD</b>   |   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>(814-38-0231)</b>                       |   | 17. INFORMANT<br>ADDRESS<br><b>M.E. Zaleskiwicz 1535 S. Charles St. 21230</b>                   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest 2° Respiratory</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arrest 2° Chronic obstructive</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>d3.</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |  |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/23</b> , 19 <b>85</b> , to <b>3/24</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>3/24</b> , 19 <b>85</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If true, check (a) and (b); if not, check (c).)  |  |  |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Willette Rahming</b>  |  |  |  |   |   | DEGREE<br><b>M.D.</b>  |   | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W. RAH MING</b>  |  |  |  |   |   | 22e. ADDRESS   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>3/27/85</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross Cem.</b>                                    |  | 23d. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>St. Pitches Highway The</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Charles H. Stevens Funeral Home Inc.</b>  |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 26 1985</b>                                  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Anna Davidson</b>   |  |

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is to be signed by the funeral director. It is to be detached for use as the burial-transit permit. Then please remove carbon papers, sign and date it, and 2 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the attending physician must complete item 22.

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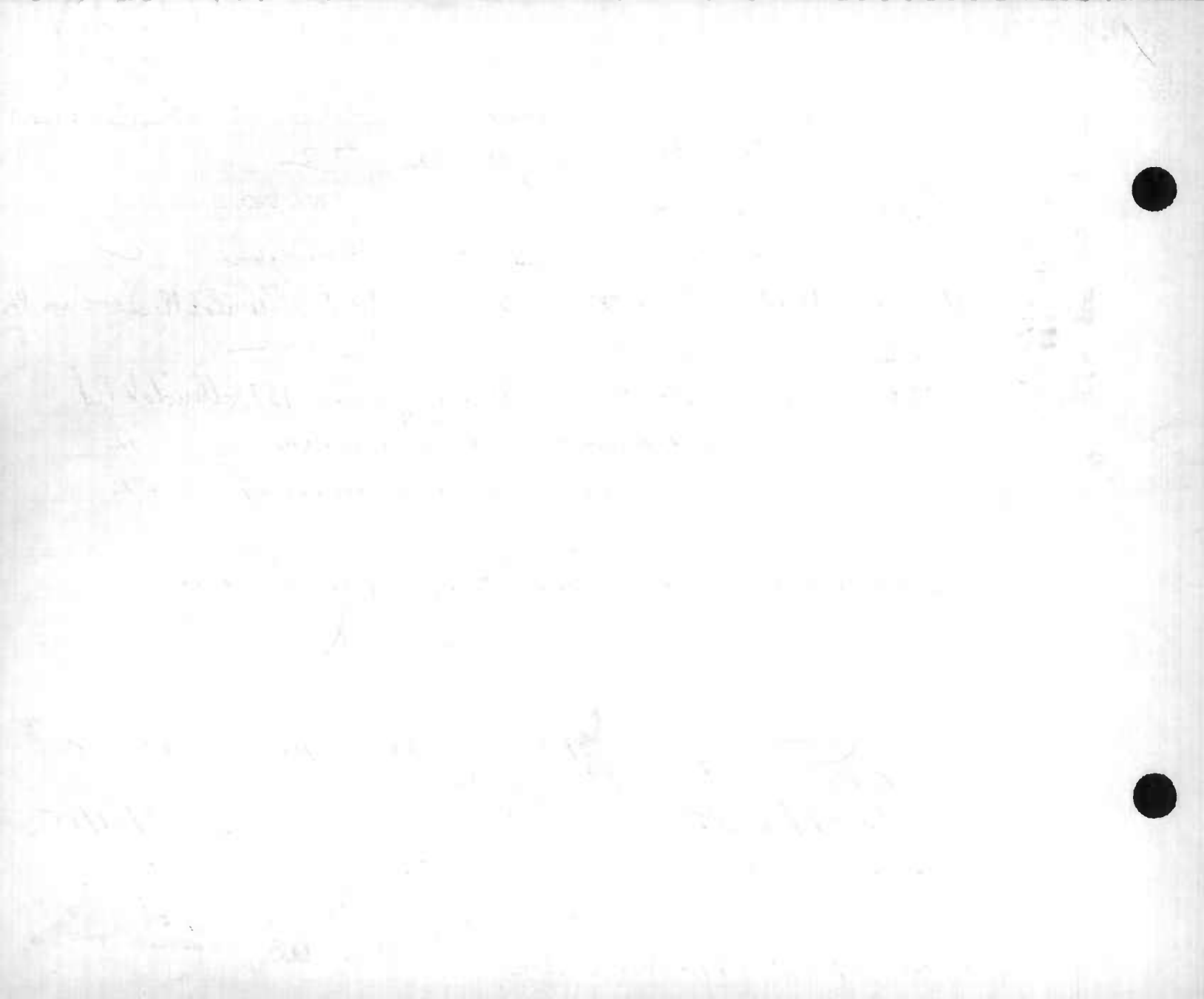
DHMH - 16 50M 4/83  
(VRA 15, 4)

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |                           |
|--|--|--|--|--|---------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MARION ZELLARS</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03 31 85</b>             |  | 2b. HOUR<br><b>9:40AM</b> |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>Black</b>                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 18 12</b>  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>72</b> YRS.                | 7. UNDER 1 YEAR<br>MONTHS DAYS<br><b>72</b>  |                           |
| 8. BIRTHPLACE<br>(STATE OR FOREIGN)<br><b>Pa.</b>  | 9. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD. |  |                           |
| 12. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b>               |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Handyman</b>   |                           |
| 15. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>Balto</b> 13c. CITY OR TOWN <b>Balto</b>  |  | 16. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 17. STREET ADDRESS / ZIP CODE<br><b>137 Seltzer Rd R. Severna Park 21146</b>         |                           |
| 18. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Chas Zeller</b>   |  | 19. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unkna</b>  |  |  |                           |
| 20a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 20b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>232-10-6803</b>  |  | 21. INFORMANT<br>ADDRESS<br><b>Allena Zeller 137 Seltzer Rd</b>                      |                           |
| 22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ELECTROMECHANICAL DISSOCIATION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PROBABLE PULMONARY EMBOLISM</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1h</b><br><b>5h</b>    |  |  |  |  |                           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>LUNG CANCER, POSSIBLE MI, CHF, POSSIBLE SEPSIS</b>  |  |  |  |  |                           |
| 23a. DATE OF OPERATION   |  | 23b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 24a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                           |
| 25a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 25b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 25c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |                           |
| 26a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 26b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 26c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                           |
| 27a. I certify that (I) (this hospital) attended the deceased from <b>3/29</b> , 19 <b>85</b> , to <b>3/31</b> , 19 <b>85</b> , that (I) (we) lost<br>saw the deceased alive on <b>3/31</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |                           |
| 28a. SIGNATURE<br><b>A. Earl Heard Esq</b>   |  | 28b. DEGREE<br><b>MD</b>   |  | 28c. DATE SIGNED<br><b>3/31/85</b>   |                           |
| 29a. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. E. HEARD MD</b>  |  | 29b. ADDRESS<br><b>601 N. WOLFE ST/BALTO MD.</b>   |  |  |                           |
| 30a. BURIAL, CREMATION, REMOVAL<br>(SEE CPT)<br><b>Burial</b>  | 30b. DATE<br><b>3-5-85</b>                   | 30c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary</b>   |  | 30d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto Md</b>                        |                           |
| 31. FUNERAL DIRECTOR<br>NAME<br><b>Irvin P. Correll</b>  |  | 31b. ADDRESS<br><b>1712 W. No. Ave</b>   |  | 32. DATE RECEIVED BY REGISTRAR<br><b>APR 3 1985</b>                                  |                           |





086089

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |   |   |   |   |                                   |
|---|---|---|---|---|-----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT)<br>ELEANOR V. ZIMMERMAN<br>ZIMMERMAN, ELEANOR V.                                 |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>3/22/85   |   | 2b. HOUR<br>4:15 AM   |                                   |
| 3. SEX<br>FEMALE  | 4. RACE<br>WHITE  | 5. DATE OF BIRTH MONTH DAY YEAR<br>1/07/09  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76   |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY MD.  |                                   |
| 10. CITY OR TOWN OF DEATH<br>BALTO.   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MASON F. LORJ |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HSWK |   | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD. |   | 13b. COUNTY<br>BALTO  | 13c. CITY OR TOWN<br>ESSEX  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>HARRY DIETRICH   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>SARAH FREDERICK   |   |   |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |   | 16b. SOCIAL SECURITY NO.<br>UNK   |   | 17. INFORMANT ADDRESS<br>CAROLYN POLLOCK 853 MIDDLESEX  |                                   |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

PNEUMONIA

DUE TO, OR AS A CONSEQUENCE OF

(b) ASPIRATION

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c) CVA

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/12, 1985, to 3/22, 1985, that (I) (we) last saw the deceased alive on 3/21/85, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Debra S. Wertheimer  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>3/22/85  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DEBRA S WERTHEIMER  |  |   |  | 22e. ADDRESS<br>5200 Eastern Ave   |  |  |  |

|   |                      |  |   |
|---|----------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL | 23b. DATE<br>3/25/85 | 23c. NAME OF CEMETERY OR CREMATORY<br>HOLLY HILL | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTO. MD. |
| 24. FUNERAL DIRECTOR NAME<br>J.G. CONNELLY          |                      | 24b. ADDRESS<br>300 MACE                         |   |
| 25a. DATE REC'D. BY REGISTRAR<br>MAR 26 1985        |                      | 25b. REGISTRAR'S SIGNATURE                       |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified prior to burial, cremation, or removal.

BP

Handwritten notes on lined paper, including the date 1/2/70 and various illegible entries.

20%  
Handwritten notes at the bottom of the page, including the word "Y" and other illegible text.

086009

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Katherine Marie Zinck   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 19 1985           |   | 2b. HOUR<br>00:55AM  |
| 3. SEX<br>Female   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 27 1899   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85<br>YRS.              | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD. |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Good Samaritan Hospital | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clerk   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Western Elec.         |   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>White Marsh                           | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>5302 Bangert St. 21162  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Zinck  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Wentzell  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]<br>No   |  | 16b. SOCIAL SECURITY NO.<br>215-10-9135A  |  | 17. INFORMANT<br>White Marsh 21162<br>Erma G. Moellman, 5302 Bangert St.                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Metabolic Encephalopathy<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Renal Failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Renovascular Hypertension<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>Aspiration Pneumonia, Chronic Lymphocytic Leukemia   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22. I certify that (this hospital) attended the deceased from 2/23, 1985, to 3/19, 1985, that (we) lost<br>saw the deceased alive on 3/19, 1985, and that in (our) opinion death occurred on the date and hour and from the causes stated<br>above, (we) (did) (did not) view the body after death.  |  |   |  |   |  |
| 22b. SIGNATURE<br>Ram Lal Mittal   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>3/19/85   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RAM LAL MITTAL  |  | 22e. ADDRESS<br>Good Samaritan Hospital<br>5601 Loch Raven Boulevard, Baltimore, MD 21239   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>Mar. 21, 1985  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore            |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore  |
| 24. FUNERAL DIRECTOR'S NAME<br>Robert C. Altenburg Funeral Home, Inc.<br>6009 Harford Rd., Balto., Md. 21214   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 21 1985  |  | 25b. REGISTRAR'S SIGNATURE<br>Rendell   |  |

MEDICAL CERTIFICATION

29

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



BP \_\_\_\_\_

DHMH - 16 50M 4/83  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO.   |  |   |   |
|--|--|--|--|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOHN</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>3-14-85</b>   |  |   |   |
| 3. SEX<br><b>MALE</b>  |  |  |  | 4. RACE<br><b>WHITE</b>  |  |   |   |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>6 02 11</b>  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.  |  |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>   |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |   |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b>   |  |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GOOD SAMARITAN HOSPITAL</b>          |  |   |   |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MECHANIC</b>  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AIRCRAFT</b>   |  |   |   |
| 13a. STATE<br><b>MARYLAND</b>  |  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  |   |   |
| 13c. CITY OR TOWN<br><b>21234</b>  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |   |
| 13e. STREET ADDRESS / ZIP CODE<br><b>9117 TOPWOOD COURT 21234</b>  |  |  |  |  |  |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GEORGE ZUBRITSKY</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANASTASIA SEPLYVCHAK</b>   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>1929-1933 213-07-3807</b>   |  |   |   |
| 17. INFORMANT<br><b>JOHN ZUBRITSKY, JR.</b>  |  |  |  | ADDRESS<br><b>WALDORF, MD. 20601</b>   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>RENAL FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>SEPSIS (E. COLI) - PNEUMONIA</b>  |  |  |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |  |  |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/10</b> , 19 <b>85</b> , to <b>3/14</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>3/14</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |   |
| 22b. SIGNATURE<br><b>R. DEPESTRE MD</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3/14/85</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. DEPESTRE</b>  |  |  |  | 22e. ADDRESS<br><b>Good Samaritan Hospital -</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>MARCH 13, '85</b>                                      |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SACRED HEART OF JESUS BALTIMORE, MARYLAND</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WILLIAM E. JOHNSON</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 15 1985</b>  |  |   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>W. Davidson-Randall</b>   |  |  |  |  |  |   |   |

